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The Development of a Psychological Check-Up:
Assessing Character and Well-being via the Unified Approach

Lindsay M. Anmuth

A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Doctor of Psychology

Combined-Integrated Clinical and School Psychology

August 2016

FACULTY COMMITTEE:

Committee Chair: Gregg R. Henriques

Committee Members/ Readers:

Craig N. Shealy

Elena Savina

Dedication

To the person who showed me that I am more than what I seek; I am already complete.

To the one who inspired me to do less and instead to be more.

To my motivation.

To Cherie.

Acknowledgements

When I started my journey at JMU, I was searching for advanced education and training. What I did not know was that I would also find the most heart-warming and intellectually stimulating group of individuals that I had ever dreamt of meeting and that I would find myself within the space that they created for me. Gregg, I will be eternally grateful for the confidence, energy, brilliance, and thoughtfulness that you modeled for me. Elena, you challenged me to think more deeply, collaborate, and weave creativity into my work. Craig, you inspired me to reject the status quo and dare to imagine the ideal. You have all left your marks on me and I plan to carry them proudly. I am honored to have been your student. Thank you for all that you are and all that you give.

Table of Contents

Dedication	ii
Acknowledgements	iii
List of Tables	vii
List of Figures	viii
Abstract	ix
 Chapter One: Introduction and Overview	 1
Brief Description of Current Findings	5
 Chapter Two: Literature review	 9
Literature review and context for the current project	9
The College Student Mental Health Crisis (CSMHC).....	10
The CSMHC and Emerging Adulthood.....	12
The Need for a New Approach to Identification and Treatment	16
A Context for the Unified Approach in the Fields of Psychotherapy & Personality.....	17
A Unified Approach to Personality, Psychotherapy, and Wellbeing.....	22
From Character Adaptations to the Character Wheel	31
Conceptualizing Well-Being: The Nested Model	35
Character Functioning & Well-Being within a Therapeutic Assessment Frame	39
Chapter Three: Developing an Assessment Protocol: The Psychological Check-Up	41
Assessing Well-Being	42
Assessing Character	42
Assessing the Five Systems of Character Adaptation.....	42
Assessing Traits	45
Assessing Identity	45
Assessing Values and Virtues	45
Assessing Abilities.....	45
Assessing Psychopathology	46
 Chapter Four: Method.....	 47
Design Overview	47
Study 1: Collecting Normative Data.....	47
Procedure	48
Participants.....	48
Measures Chosen for the Psychological Check-Up and Completed in Study 1.....	49
Demographic Questionnaire	49
Assessment of Well-Being.....	49
Assessment of 5 Systems of Character Adaptation	50
Measures Associated with the Habit System	50
Measures Associated with the Experiential System	51
Measures Associated with the Relational System	52
Measures Associated with the Defensive System.....	52

Measures Associated with the Justification System	53
Assessment of Traits	54
Assessment of Identity	55
Assessment of Values and Virtues	55
Assessment of Psychopathology	56
Quantitative Analyses	57
Study 2: Conducting the Psychological Check-Up	57
Procedure	58
The Online Assessment Battery	58
Recruitment for the Psychological Check-Up	
Interview & Feedback	59
Additional Assessments in Part 2: The Psychological Check-Up	59
Semi-Structured Interview	59
Providing Feedback	60
Feedback Questionnaire	60
Follow-Up Feedback Questionnaire	61
Part 2 Participants	61
Analyses of Feasibility and Utility	63
Chapter Five: Results	64
Results of Study 1	64
Collection and Examination of Normative Student Data	64
Results of Study 2	69
Comparison of the Samples	69
Examination of the Psychological Check-Up Protocol: Feasibility and	
Utility	71
Case Studies of Psychological Check-Up Participant Experiences	72
Case #1: “Anna”	72
Case #2: “Barb”	79
Case #3: “Chloe”	86
Case #4: “Diane”	93
Participant Case Studies: Conclusion	100
Feasibility: Creating and Implementing the Psychological Check-Up	101
Feasibility: Development of a Psychological Check-Up Protocol	101
Feasibility: Implementation of the Psychological Check-Up Protocol	101
Clinical Utility of the Psychological Check-Up	104
Clinical Utility: Reflective Assessment of Each Component’s Utility	104
Clinical Utility: Overall Accuracy of the Conceptual Feedback	
Report	108
Clinical Utility: Participant Feedback about Overall Utility &	
Meaning	110
Chapter Six: Discussion	113
Discussion of Psychological Check-Up Study 1	115
Current Trends in JMU Student Profiles	115
Discussion of Psychological Check-Up Study 2	118
The Pilot Version of the Psychological Check-Up Protocol:	

Areas for Growth	121
Conclusion	126
Implications and Future Directions.....	128
Appendices:	
Appendix A: The Psychological Check-Up: A Normative Study (advertisement)	133
Appendix B: Informed Consent Forms.....	134
Appendix C: Demographic Questionnaire.....	138
Appendix D: Henriques 10-Item Well-being Scale (H10WB)	139
Appendix E: Influence Matrix Social Motivation Scale-Short Form (IMSMS-SF)	143
Appendix F: Study 2 standardized email contact message	145
Appendix G: Semi-Structured Interview	146
Appendix H: Feedback Questionnaire	152
Appendix I: Follow-Up Feedback Questionnaire	153
Appendix J: Case Study #1: “Anna”	154
Appendix K: Case Study #2: “Barb”	159
Appendix L: Case Study #3: “Chloe”	165
Appendix M: Case Study #4: “Diane”	170
References	174

List of Tables

Table 1: Means and Standard Deviations for Psychological Check-Up Assessment Measures

List of Figures

Figure 1: Character Adaptation Systems Theory (CAST) Model

Figure 2: The Tripartite Model of Human Consciousness (Henriques, 2011)

Figure 3: The Character Wheel

Figure 4: The Nested Model of Well-Being (NM, Henriques et al., 2014)

Abstract

This dissertation presents a model of assessing and addressing the growing college student mental health crisis (CSMHC), which pertains to the rise of student pathology over time and difficulty meeting the needs of that growing population. A theory driven conceptual paradigm was developed, based on Henriques' (2011; Henriques & Stout, 2012) Unified Approach to psychology and psychotherapy and, specifically, the Nested Model of Well-being (Henriques, Kleinman, & Asselin, 2014) and Character Adaptation Systems Theory (CAST). Based on those conceptual models and an understanding of college student mental health concerns, the Psychological Check-Up was designed. The Psychological Check-Up consists of a comprehensive assessment battery, wherein students complete brief measures online, schedule in-vivo interviews with clinical researchers and return for therapeutic feedback and a written report of their well-being, character functioning, and recommendations for greater adaptive living. The current project constituted the pilot phase and, as such, contained two distinct studies. In Study 1, the clinical researchers collected normative data from a large sample of college students who completed the Psychological Check-Up assessment battery online. In Study 2, a second sample of college students (n=19) completed the entire Psychological Check-Up protocol. Results of this pilot phase indicated that the Psychological Check-Up was judged to be highly feasible, clinically useful, and meaningful for participants. Thus, it is the clinical researchers' belief that the Psychological Check-Up is an effective method of assessing and addressing the CSMHC as the proposed protocol represents a method of identifying and treating at-risk individuals in a way that is efficient, systematic and also theoretically grounded.

Chapter One

Introduction and Overview

This project represents the intersection of two emerging developments. The first is Henriques' (2003; 2011) new unified approach to psychology and psychotherapy. The second is the growing college student mental health crisis. The goal of this project was to develop a comprehensive way to efficiently assess character functioning and well-being in college students. The vision is that this assessment and formulation can serve as a new and valuable health care tool. Specifically, it portends the development of a "psychological checkup", whereby in a relatively brief assessment and consultation period, individuals may be provided with a detailed formulation of their overall character structure and levels of psychological well-being. The hope was that individuals might use this formulation as a guide for increased adaptive living.

Although the current assessment protocol may eventually have implications for the population at large, its initial design was geared toward a specific population. That target population consists of college students in the university setting. This population was targeted because there have been identifiable increases in college student mental health problems (Kadison & DiGeronimo, 2005; Gallagher, 2012), most notably striking increases in stress, depression, and anxiety (ACHA, 2009) and concerns that many who are suffering are not seeking help (Eisenberg, Hunt, Speer, and Zivin, 2011). Further, many wonder whether college counseling centers are truly prepared to meet the mental and developmental needs of their students, especially given rising levels of distress (Benton, Robertson, & Tseng et al., 2003; Mowbray, Mandiberg, & Stein et al., 2006).

Although many different kinds of assessment protocols have been developed, this is the first comprehensive assessment protocol grounded in a unified theory of human psychology. Other approaches have been developed based either on specific psychotherapeutic paradigms (e.g., cognitive psychotherapy) for diagnostic purposes (the Structured Clinical Interview for the DSM) or via purely empirical and statistical analyses (e.g., Big Five, MMPI-2). In contrast, the assessment of character and well-being articulated here is grounded in a coherent formulation of human psychological functioning that is: a) consistent with the modern science of human psychology in general and personality and psychopathology in particular; b) consistent with the major paradigms in psychological assessment and therapy (e.g., cognitive behavioral, modern psychodynamic and humanistic traditions); and c) yields a map of human functioning that is believed to be readily understood by clients in a way that will potentially foster more adaptive psychological patterns.

Henriques has been developing and refining his approach for a unified psychology for almost 20 years. In the early publications, Henriques (2003; 2004; 2005) focused primarily on why psychology lacked a meta-perspective that defined the field, why such a meta-perspective was needed, and how his formulation could fill that gap. Following the publication of the outline of his ideas in book form (Henriques, 2011), the focus of his work has shifted from the argument for the unified approach from the vantage point of providing a meta-perspective to the development of models and methods that can be applied in real world settings.

For example, based on the unified approach, Henriques and Stout (2012) articulated a way to develop holistic conceptualizations that they argued would lead to

the development of effective interventions. Specifically, the authors articulated an approach to conceptualizing people in psychotherapy that coherently integrated a biopsychosocial view with modern research in personality and the major perspectives in individual psychotherapy (i.e., behavioral, cognitive, psychodynamic and humanistic). One of the most novel features of the system developed by Henriques and Stout was the formulation of a new “big five” for characteristic adaptations (McAdams & Pals, 2006) that cut across the major psychotherapy paradigms. This formulation, which was subsequently delineated as Character Adaptation Systems Theory (Henriques, 2016), articulated a vision for dividing the systems of character adaptation into five related but separable domains as follows: 1) the habit system; 2) the experiential system; 3) the relationship system; 4) the defensive system and 5) the justification system. Henriques (2013) argued that viewing character through this lens allows for the integration of key insights across major paradigms of individual psychotherapy. Specifically, the habit system corresponds to the behavioral paradigm, the experiential system corresponds to an emotion focused perspective, the relational and defensive systems correspond to a modern psychodynamic perspective, and the justification system corresponds to the cognitive and narrative (or existential) perspectives.

This formulation led to some practical applications. For example, Glover (2013) utilized the five systems of character adaptations to develop a group intervention for long-term residential psychiatric patients, and found evidence of its utility. Mays (2015) developed an individualized intervention for college students based on the formulation. The intervention emphasized character functioning and adaptive living, which relied heavily on Henriques’ conception of well-being. Henriques, Kleinman and Asselin

(2014) articulated how Henriques' unified approach provided a general framework for delineating the key domains that make up human well-being, called the Nested Model of well-being. In terms of practical applicability, this formulation resulted in a classroom experience that was empirically demonstrated to foster well-being in college students, as compared to controls (Henriques et al., 2014).

The current project represents an attempt to consolidate these developments into a comprehensive protocol for assessing character functioning and well-being with a specific societal application in mind. The protocol includes a battery of assessments, each of which has been chosen to assess a specific aspect of character adaptation. Following the 5-system model developed by Henriques and Stout (2012), Henriques has recently expanded on his vision of character and well-being. According to Henriques' new map of character and well-being, individuals should be assessed in the areas of identity, traits, pathologies, abilities, and values and virtues, in addition to their individual character adaptations. The current project represents an effort to design and implement a battery to assess each of these aspects of well-being and character domains. For accurate scoring purposes, the project collected normative data for a sufficient sample of university students before completing the character and well-being assessment protocol on nineteen college students. In so doing, the assessment protocol was evaluated for its feasibility and utility.

After collecting normative data, the primary goal of the project began: the implementation of the assessment protocol. Participants self-selected to engage in a study on developing a "psychological checkup." They then completed the quantitative portions of the assessment online. Following that, each willing participant engaged in a semi-

structured interview. As such, qualitative contextual information was added to the clinical picture indicated by the quantitative assessment data. All of the information was then utilized in the generation of a written report of well-being and character functioning. Finally, the participants returned for the “informing” or feedback session, which consisted of a face-to-face session during which written and oral feedback were provided to the student. Through the use of these three phases, this project provided an efficient, accurate, and meaningful conceptualization as well as a set of individually tailored recommendations for each participant.

Study 2 of the current project constituted the “psychological check-up.” The psychological check-up was operationalized through development of a working manual. Implementation then consisted of 19 therapeutic assessments, as outlined above, that served to test the feasibility and utility of the proposed procedure.

Brief Description of Current Findings

Results of Study 1 consisted of means and standard deviations for all psychological check-up screening measures administered to a sample of university students ($n = 104$; 56% female, mean age = 19, 62.5% single). Examination of those results revealed an overall level of well-being in the “somewhat high to high” range, with specific domains of functioning ranging from “mixed” to “somewhat high to high.” The sample was characterized by medium-high scores for the big 5 traits of conscientiousness, openness, and agreeableness. Interpersonally, our responses indicated that they experienced high relational value, tended to affiliate with others, were slightly more dominant than submissive in their relationships, and typically maintained a balance

of autonomy and dependence on others. Despite those adaptive qualities, the average participant did endorse mild levels of both depression and anxiety, with 20% endorsing at least moderate depression and 5% endorsing a moderate level of anxiety. Regarding participant habits, there was an overall negative screen for illicit substance use and disordered eating; however, the average participant indicated somewhat poor sleep hygiene and greater than half of the sample endorsed problematic levels of alcohol consumption. Responses revealed average levels of both positive and negative affect as well as overall level of distress and dysfunctional attitudes. Participants endorsed high average coping self-efficacy; however the average participant also indicated potentially unhelpful defenses such as suppressing aggression and taking on excessive responsibility. Students characterized their parents as significantly overprotective but much lower in overall level of caring.

Study 2 results consisted of qualitative information about the “psychological check-up” experience as implemented in a second sample of university students ($n = 75$, 67% female, mean age = 19.7, 70.7% single). The two samples were reasonably similar, although they did significantly differ on two demographic variables (the first sample was younger and more likely to be underclassmen) and two dependent screening variables (the second sample endorsed greater impulsivity and alcohol use). Participants completed the online assessment battery and were subsequently contacted with an opportunity to meet with a researcher to complete an interview and receive a report of their well-being and character functioning; there were 3 statistically significant differences, with those who went on to engage in the entire psychological check-up protocol endorsing lower levels of self-rated power, giftedness, and relational autonomy.

The Study 2 psychological check-up protocol was examined for its feasibility and utility. Evaluations of those criteria were predicated on participant feedback and the clinical researchers' professional judgment. The psychological check-up protocol indeed demonstrated a high degree of feasibility. The researchers were able to design a new therapeutic assessment protocol that corresponded to Henriques' conceptual models of well-being and character functioning and that quantified participant profiles according to established measures. The protocol was standardized across its various stages, including recruitment, administration, scoring, semi-structured interview, interpretation, write-up, in-person feedback, recommendations, and follow-up contact. Based on successful creation and implementation, the protocol was judged to meet the feasibility benchmark. The psychological check-up also demonstrated clinical utility. Further, each component of the protocol contributed unique utility and meaning. The online assessment battery afforded a broad snapshot of participant functioning that informed the structure of the interview. The interview allowed participants to share their narrative histories and gave the clinical researchers insight into participants' unique worlds through behavioral observations, attunement, and language. The feedback phase consisted of sharing important and sensitive conceptual information as well as recommendations for greater adaptive living and allowed the clinical researchers to do so by way of an established therapeutic connection. Finally, participants were given the opportunity to provide feedback about the process and about their own experiences; participant feedback at each time point (directly after the session and 2 weeks later) were overwhelmingly positive, with each participant commenting on the level of accuracy and meaning of their results. Therefore, based on participant feedback responses and the researchers' professional

judgment, the psychological check-up was deemed to be a clinically useful assessment protocol.

Chapter Two

Literature Review

The goal of the current project was to develop, implement, and evaluate a brief comprehensive assessment package for college-aged individuals. The assessment consisted of three components: 1) administration of an online assessment battery; 2) a semi-structured interview with each participant; and 3) a second meeting, during which written and oral feedback concerning character functioning and well-being were shared with the participant to foster understanding and offer a guide toward more adaptive living in the future. Well-being was conceptualized according to the Nested Model of Well-being (Henriques, Kleinman, & Asselin, 2014) and character functioning was conceptualized according to Henriques' (2011) unified approach to human psychology and psychotherapy and his recently proposed Character Adaptation Systems Theory (CAST; Henriques, 2016).

Before presenting the assessment intervention in detail, a context will be provided for why it is needed. First, the current status of college student mental health will be reviewed, as the target population in this particular case consists of college students. More specifically, the rise in college student psychopathology in recent years, which has been deemed a "college student mental health crisis" (CSMHC; Henriques, 2014), will be discussed and subsequently contextualized within a review of broader explanatory frames as well as the current status of mental health on college campuses. This will provide a context for the current approach. From there, Henriques' conceptualizations of character and well-being will be introduced and discussed, as it provides the basis for the current integrative assessment frame.

The College Student Mental Health Crisis (CSMHC)

In the United States the prevalence rates of individuals dealing with significant levels of negative affect are disconcerting. According to Kessler (2012), among United States adolescents and adults, the estimated lifetime morbid rate (LMR) of mood disorders is 30.7% and of anxiety disorders is 41.7%. Further, additional epidemiological studies have demonstrated that, taken together, the one-year prevalence of all psychiatric disorders is at its greatest for those aged 15-21 years (Mowbray, Mandiberg, & Kopels et al., 2006).

Recent data suggest that college students are at particular risk for developing anxiety and depressive disorders. According to a report conducted by the American College Health Association (ACHA; 2009), the prevalence of depression among college students was 14.9% and, of those, 32% had been diagnosed sometime during the past 12 months. Further, 59% reported feeling hopeless at least once over the past year and 12.3% reported feeling hopeless greater than nine times throughout the year. A significant proportion, 43%, reported that at least once over the past year they had “felt so depressed it was difficult to function” (p.487).

With mental health concerns occurring at such high levels, a logical question becomes whether these represent stable prevalence rates or increases in pathology over time. To that end, the Association of University and College Counseling Center Directors (AUCCCD) sought to better elucidate the perceived increase in demand for college counseling. In 1981, the AUCCCD conducted an annual survey of American college counseling directors. Analysis of 30 years of data concerning experiences, opinions, trends, problems, and solutions revealed several important trends and implications

(Gallagher, 2012). Perhaps the most notable trend was the increase in student pathology over time. The 1988 survey was the first to inquire as to whether there had been an objective increase in the proportion of students who presented with serious mental problems. Of those surveyed, 56% of college counseling directors responded that, indeed, their centers were seeing more serious pathology. In 2001, this percentage further increased to 83% and, in 2007, rose to 92%. In addition, college counseling center directors have reported a significant increase in the proportion of college students who are taking psychotropic medications. In 2011, an estimated 23% of college students held a prescription related to a mental health concern, as compared to only 9% fifteen years before.

For college students, mental health concerns rank highly among all other health-related concerns. The American College Health Association (ACHA; 2009) administered the ACHA-National College Health Assessment to a large sample of university students across 106 self-selected institutions (n=80,121) and student participants were asked to rank order their top health concerns according to what they had experienced over the past year. Results of the survey showed that, of the top ten health concerns, depression was ranked #4, with 17% of students reporting experiencing significant feelings of depression over the past year. Depression was outranked only by allergy, back pain, and sinus infection. The #6 concern among college students was anxiety, with 13.2% of individuals reporting problems with anxiety over the past year. The 2013 iteration of the ACHA survey (ACHA-NCHA-II) showed that, over the past year, academic performance had been significantly impacted by a number of mental health concerns. These concerns

included stress (28.5% of students), anxiety (19.7%), depression (12.6%), and relationship difficulties (9.7%).

Results from this survey further revealed just how widespread mental health concerns, in particular concerns related to anxiety and depression, truly are. To illustrate, students endorsed the following symptoms over the past year: hopelessness (45% of students), feeling overwhelmed (83.7%), feeling mentally exhausted (79%), feeling lonely (55.9%), feeling very sad (59.6%), feeling so depressed that functioning became difficult (31.3%), overwhelming anxiety (51%), overwhelming anger (37%), seriously considered suicide (7.4%), attempted suicide (1.5%), and self-injurious behavior (5.9%). Of all students polled, 22.2% had received a diagnosis or treatment for anxiety, obsessive-compulsive disorder, panic attacks, or phobia and 11% reported a diagnosis or treatment for depression. Thus, it is clear that college students are endorsing increasingly high rates of mental health concerns. What is potentially less clear is the explanation as to why that is. For this, the following section offers a broad explanatory frame, rooted in a developmental and systemic model.

The CSMHC and Emerging Adulthood

It is beneficial to consider college students not as existing in a vacuum, but within a larger developmental frame. The college years can be further contextualized within a distinct developmental period: emerging adulthood (Arnett, 2000). The term “emerging adulthood” has been used to describe the stage that occurs between adolescence and adulthood, which is thought to take place between the ages of 18 and 25 (Arnett, 2000). According to Arnett (2000) who coined the term itself:

Emerging adulthood is distinguished by relative independence from social roles and from normative expectations. Having left the dependency of childhood and adolescence, and having not yet entered the enduring responsibilities that are normative in adulthood, emerging adults often explore a variety of possible life directions in love, work, and world-views (p.469).

The notion that emerging adults are at a unique stage during which confusion and identity crises abound provides some contextual understanding for why depression, anxiety, and other psychiatric disorders might be more likely to arise at this time. A recent study showed that prevalence rates of numerous psychiatric disorders have increased in 18 to 24-year-old individuals, regardless of whether those individuals attended college or not (Blanco, Okuda, & Wright et al., 2008). Their findings come from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which surveyed a representative sample (n=43,093) over the 2001-2002 year. As an estimated 87% of college students are between the ages of 18 and 24 years (ACHA, 2006 as cited in Blanco et al., 2008), that age group was targeted in the analyses (college-attending, n=2188; non-college-attending, n=2904). Broadly, results revealed that although college students and same-aged peers were largely similar in their psychiatric profiles, there were a few exceptions. College students were significantly more likely to endorse alcohol dependence and less likely to endorse nicotine or other-drug dependence. Thus, the results of this study (Blanco et al., 2008) suggest that the mental health crisis is a reflection of a larger young adulthood phenomenon. However, for the purpose of the current work, it will be important to form a holistic picture of the challenges faced by emerging adults as well as the unique experiences of college students, specifically. For this, a contextual understanding of development and broader societal trends will be offered.

Emerging adults, and perhaps college students more specifically, have been subjected to changing practices within the American family. The modern American family has become increasingly achievement focused, so much so that many prominent psychologists and experts in higher education are concerned about the messages that are sent, both explicitly and implicitly, to adolescents and students transitioning to college. As a result of research and personal interviews with parents, teachers, and students, Harvard professor Richard Weissbourd (2011) believes that academic achievement has become the value that is most prominently fostered in children. He offers, “A child who is socially skilled, deeply loyal, funny, feisty, caring, and imaginative may never come to value these qualities or see them as anywhere near the core of his or her being. In these circumstances, children are also more likely to view others in terms of their achievements and see them as competitors or threats. They suffer both a diminished sense of others and a diminished sense of themselves” (p. 24). The American education system, as well as education systems around the world, similarly promotes the high achievement, pressured, anxiety-ridden culture that surrounds today’s high school and university students.

While today’s youth are placed on a perceived fast track toward academic success and prized for their achievement, this appears to have left less room for emotional health and character development. Indeed, the current generation of college students has seen the rise of the “tiger mother” (Chua, 2011), who promotes academic pressure, high achievement standards, and fear of authority. At the same time, many students continue to experience the “helicopter parent” well into their college years, wherein parents remain overly involved in even the most minute and manageable aspects of their children’s lives. Although such parents believe that they are helping by maintaining frequent contact with

their children and attempting to solve their personal and academic problems for them, recent research suggests that the reverse might be true. In a survey of 482 undergraduates, Bradley-Geist and Olson-Buchanan (2014) found that “overparenting” was significantly associated with lower student self-efficacy and decreased ability to manage problems in the workplace. As a potential explanation, perhaps the culture of high achievement, low emotional maturity, and underdeveloped problem solving skills has contributed to the low distress tolerance seen in today’s college students.

College students have always been subjected to academic rigor; however, many are concerned that today’s college students are ill-prepared to transition from high school to college-level demands. Chief among those concerns may be the notion that today’s high school students enjoy inflated grades. In this way, students might receive an A for work that, for students in the past, would have earned a B or C. A recent study conducted by the College Board (Godfrey, 2011) found that grade point averages (GPAs) have increased by 0.26 from 1996 to 2006. Further, there was a great deal of variability in grades assigned for similar work across schools. This academic rigor and ill-preparedness logically leaves college students to feel overwhelmed, anxious, and hopeless about their academic futures. These feelings then become reflected in rates of distress and mental illness.

Of course, over time, a greater and broader range of individuals has gained access to a college or university education. In the past, those struggling with existing mental health concerns might not have sought higher education at the same rate; however, with increased access and aid, campuses now include greater numbers of individuals suffering from severe mental illnesses, negative affect, personality disorders, and various physical

and cognitive disabilities, as well as economic disadvantage. Inherently, thus, rates of mental illness among college students would be expected to increase.

In summary, this section has outlined several contributing explanations for the CSMHC, including a contextual understanding of college students' developmental stage, changing value structures, and more widespread access to higher education. At the same time, students have enjoyed inflated grades during adolescence, which has exacerbated the sense of alarm felt when they experience increased rigor and demands in college. As discussed, implications of such societal issues appear to include a new generation of emerging adults who, on the one hand, endorse high achievement needs but, on the other hand, might be underdeveloped in emotional maturity, problem-solving ability, and self-efficacy. Data suggest that mental health concerns are highly endorsed by college students; however, treatment seeking is not. Therefore, the combination of exploration, vulnerability, and widespread need form a group of individuals that necessitate an appropriately targeted and direct intervention.

The Need for a New Approach to Identification and Treatment

The increasing levels of mental health problems in emerging adults in general and college students in particular point to the need for new and innovative approaches to mental health. Thus, the above review serves as the context for the current proposal. At a general level, the current project stems from the point of view that the field of mental health is ill-prepared, and in much need of a coherent conceptual frame to address such widespread need. Mainly, what is needed is a large-scale method of identifying and

treating at-risk individuals in a way that is, at the same time, quick, efficient, and theoretically informed.

What will be made clear in the following sections is that there is much systematic misunderstanding about things such as personality, well-being, and character functioning that prevent the mental health industry from effectively coordinating its response to such a pervasive need for services. There are also problematic models of mental health and fragmentation between the science and practice of psychology and other mental health disciplines.

A Context for the Unified Approach in the Fields of Psychotherapy and Personality

The current project is grounded in what is termed the “unified approach.” The unified approach is poised to address large-scale mental health needs, which includes the CSMHC. It provides a comprehensive framework from which to understand human psychology, a mechanism for psychoeducation, and a deepening of our understanding of human psychopathology and well-being. The unified approach to conceptualization and treatment was borne from a larger movement to consolidate complementary evidence-based theories.

Over the past few decades, there has been a growing disaffection with the competing “single-school” approaches within the field of psychotherapy. Out of this concern has grown what is now identified as the “psychotherapy integration” movement, which began in the 1970s and gained substantial momentum in the 1980s. As such, today, “integrative” is the modal theoretical orientation of psychotherapists (Norcross, 2005).

An understanding of psychotherapy integration is intimately related to the current project, as it represents a new broad-based integrative model. Just as vital is an awareness of the ways in which psychotherapy integration offers an inclusive frame through which to assimilate otherwise divergent domains. It is important to recognize that beyond the rapprochement of various schools of thought in psychotherapy, the integration movement also allows for the joining of psychotherapy and personality theory, two psychological fields that often operate in parallel to one another with surprisingly little crosstalk.

Prominent personality theories include the five-factor, or “Big-5” model of personality traits (Costa & McCrae, 1994), Erik Erikson’s psychosocial stages of development (Erikson, 1959), and the humanistic ideal of a drive toward personal growth and self-actualization (see Maslow, 1943 and Rogers, 1961). More recently, research in personality theory has surged. For example, McAdams and Pals (2006) developed a broad framework for assimilating the historically divergent schools of thought in personality. Their model was outlined in a well-received *American Psychologist* paper entitled, “A New Big Five,” and is the product of integrating dominant areas of psychological science for the purpose of conceptualizing the holistic individual. A review of McAdams and Pals (2006) sets the stage for the new integrative paradigm proposed by Henriques (2011) and utilized within the current project.

The New Big Five (McAdams & Pals, 2006) consists of 5 distinct scientific principles for conceptualizing personality. Its foundation begins with the first principle, which they label “Evolution and Human Nature,” posits that human beings represent a species that has genetically evolved according to environmental presses over time. As such, human beings share a common foundation and individual differences subsequently

arise from that core. From the basic understanding that human beings exist within an evolutionary context, the other schools of thought may then apply their various theories of what drives human beings at an ontogenetic level of analysis. Principle 2 was labeled the “Dispositional Signature,” which posits that trait theories are employed to explain broad and theoretically stable individual differences. Traits are dimensional styles of being that distinguish individuals from one another, but that remain relatively stable across situations and environmental contexts. The most parsimonious and widely adopted frame that exists at this level of analysis is the five-factor or “Big-5” model of personality traits, which conceptualize individual personalities based on the degree to which they endorse openness, conscientiousness, extraversion, agreeableness, and neuroticism (Costa & McCrae, 1994).

Principle 3 is that of “Characteristic Adaptations.” At this level, human personality rests on its evolutionary foundation, is guided by a unique emphasis of dispositional traits, and begins to take environmental context, motivation, and ontogenetic drives into consideration. Specifically, the framework for understanding characteristic adaptation are individuals adapting to the environment, both material and social, and is often characterized by strategies, values, rules of operation, and relational schemas, among others. Though the authors state that much research is being conducted in the area of characteristic adaptations, at the time of publication, a method of organizing characteristic adaptations into a coherent frame did not exist. Since that time, however, a framework for understanding characteristic adaptations has been proposed (e.g. Henriques & Stout, 2012) and will be discussed in a later section.

Principle 4 is labeled “Life Narratives and the Challenge of Modern Identity” (McAdams & Pals, 2006). This domain pertains to the level of human identity and self-concept and it posits that individuals differ in the ways in which they organize, explain, and narrate their experiences and life histories, which in turn moderate their methods of interacting in the world. Accordingly, much can be learned about individuals by the way that they tell the stories of their lives, the words that they choose to employ, their methods of linguistically organizing their thoughts and beliefs, and the ways in which they maintain a consistent sense of self.

The fifth and final principle proposed by McAdams and Pals (2006) is “The Differential Role of Culture.” Broadly, culture pertains to an individual’s immediate social environment as well as the set of shared rules, demands, and explanations dictated by a particular culture, during a particular time in history. Language provides the medium through which individuals access the content and spirit of their culture. In so doing, culture provides the context in which individuals learn, develop, and grow; it also influences individuals’ intrinsically held beliefs and justifications and places unique demands for particular behaviors or expressions.

Though McAdams and Pals (2006) provide a comprehensive integrative frame for understanding the whole person, from the vantage point of the unified approach, lacks a detailed and more micro-level approach to understanding characteristic adaptations. In particular, McAdams and Pals’ (2006) principle 3 is intimately related to the current project. Principle 3: Characteristic Adaptations holds that human beings differ with regard to the ways in which they adapt to their surroundings, the cognitions that they hold, what they strive to achieve, what they value, and how they conduct themselves.

Principle 3 constitutes a crucial level of analysis; however, it also only represents a placeholder for the specific “middle-level units” (Buss & Cantor, 1989 in McAdams & Pals, 2006) that exist at that level. The authors would agree with this statement, as they offer, “...there exists no definitive, Big Five-like list of these kinds of constructs...” (p. 208).

Fortunately, a model of specific domains of characteristic adaptations has been subsequently introduced. Henriques has recently developed a new integrative framework entitled Character Adaptation Systems Theory (CAST), which builds upon earlier conceptions (Henriques, 2011; Henriques & Stout, 2012) and offers a framework for understanding the whole person across five specific domains, therefore filling in the details that are missing from McAdams and Pals’ (2006) model of personality. Those five systems are: the Habit system, the Experiential system, the Relational system, the Defensive system, and the Justification system. Operating through the lens of these five systems allows clinicians to conduct a more micro-level analysis of personality and, more broadly, to conceptualize the whole person. In this way, the CAST model provides a bridge between McAdams and Pals (2006) macro-level principles of human personality and an idiographic, integrative, and applied clinical approach to conceptualization and treatment. Most importantly, the CAST model proposed by Henriques fills a gap in the psychotherapy movement. As described in the following section, the model offers an effective, holistic, and integrative vision for conceptualization and psychotherapy integration.

A Unified Approach to Personality, Psychotherapy, and Well-Being

Henriques (2003) introduced his Unified Theory (UT) as a method of defining the field of psychology as it relates to the other branches of science. In order to do so, he presented a coherent frame for integrating the dominant schools of thought in psychotherapy, i.e. psychodynamic, behavioral, cognitive, and humanistic, for purposes of study, conceptualization, and practice.

Making use of several theoretical components of the UT (e.g. the principles of behavioral investment theory, justification systems, and the influence matrix), Henriques (2011) introduced an integrative, contextualized biopsychosocial model termed the Unified Component Systems Approach to Conceptualizing People. As can be seen in Figure 1, the individual, represented by a circle at the center of the map, is evaluated within 3 broad contexts.

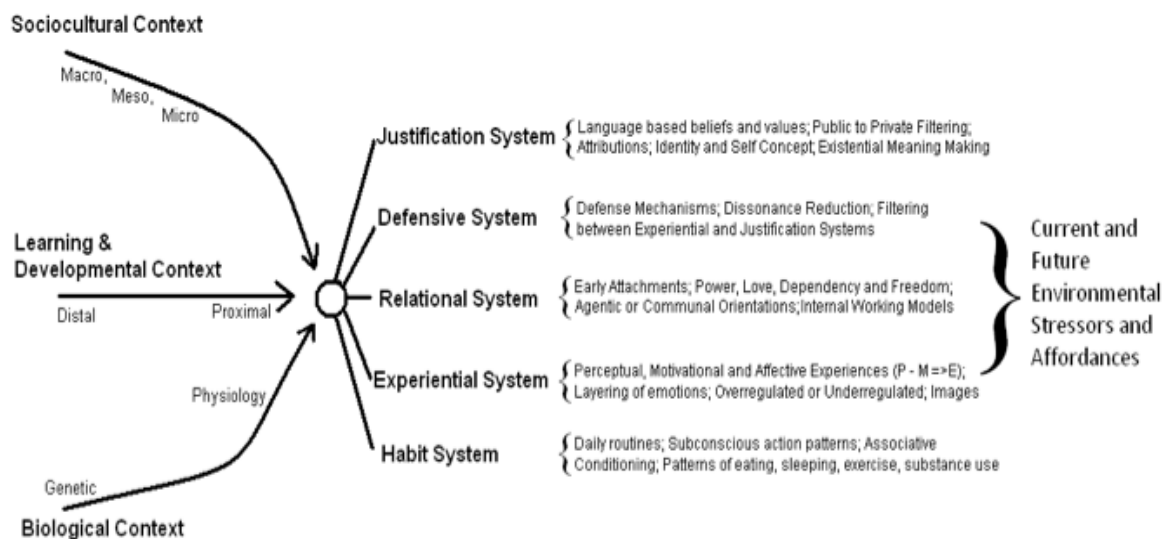


Figure 1: Character Adaptation Systems Theory (CAST) Model

The sociocultural context pertains to an individual's macro-level cultural practices, values, and environmental pressures. It also relates to the social role that they play within their families, work and educational settings, and peer groups. Socioeconomic status, as well as an individual's social status within their community, is also crucial components to consider when conceptualizing the whole person. The Learning & Developmental context pertains to the various contingencies and formative variables that individuals have experienced over the course of their lifetime. In particular, clinicians must assess for early attachment and parenting histories, whether or not core needs were satisfied, the ways in which individuals were reinforced or punished, their successes and failures, episodic memories that caused a particular impact on their understanding of self, and also the psychosocial stage that individuals currently endorse. The biological context pertains to 3 subdomains: evolutionary considerations, genetics, and physiological health status. In a way that is similar to McAdams and Pals (2006), Henriques (2011) argues that individuals must first be considered within the context of a long evolutionary history wherein behaviors were shaped according to their adaptive fit (see the earlier section on Behavioral Investment Theory). The consideration of individuals' genetic make-up is also an important component. Genes have been implicated in highly heritable psychiatric disorders such as Bipolar I disorder and Schizophrenia; however, genes have also been implicated at the level of personality traits and cognitive ability, which may have a substantial impact on identity and self-concept. Finally, the physiological subdomain pertains to an individual's physical health status. Disease, bodily trauma, and pain, among other maladies, can have a powerful impact on

an individual's identity and psychological health and should be considered within the larger biological context.

After conceptualizing individuals according to their sociocultural, learning & developmental, and various biological contexts, clinicians utilizing the Unified Component Systems Approach (Henriques, 2011) then evaluate individuals according to the 5 systems of characteristic adaptation. The 5 systems are: the Habit System, the Experiential system, the Relational system, the Defensive system, and the Justification system.

The Habit system consists of automatic, e.g. habitual, mental processes and behaviors (Henriques & Stout, 2012). In this way, an individual's habits include reflexes and procedural memories that lie outside of their conscious awareness but also include complex overlearned behavioral patterns. According to Henriques and Stout (2012), "...the lens of the habit system corresponds to looking at an individual's daily routines, general activity levels, patterns of eating, sleeping, substance use, sexual activity and exercise, and stimuli or triggers that evoke particular kinds of response patterns" (p. 51).

In psychotherapy, clinicians may look to an individual's habit system to understand client problems such as substance use as well as the ways in which a client maintains their anxiety through avoidance and withdrawal. The habit system is the domain of behavioral psychotherapy. Behaviorally oriented clinicians look to explain an individual's presenting concerns based on their unique learning history. Learning history refers to all of the events and contingencies that an individual has experienced, including the behaviors that have been reinforced as well as those that have been punished. Therapy aims to identify specific triggers for maladaptive behaviors, to alter the individual's

environment, and to change their responses to that environment so as to shape more adaptive behaviors.

For instance, behavioral therapy may operate within the individual's habit system to identify the environmental factors that may be maintaining their substance abuse, set clear and identifiable goals for decreasing use, and shape new methods of coping with distress (McCrary, 2008). As another example, cognitive behavioral therapy (CBT) may be employed to conceptualize and treat acute anxiety, as in panic disorder. Operating within the lens of the habit system, CBT works to identify environmental or internal triggers for panic as well as factors that might be maintaining an individual's anxiety and subsequently induces a panic response with the goal of showing the individual that they have little to fear (Craske & Barlow, 2008). In this way, the strength of the anxiety and avoidance are reduced and the individual is reinforced for relaxing rather than panicking.

The Experiential system consists of images, impulses, emotions, and other sensory experiences. According to Henriques and Stout (2012), "Examples of experiential phenomena include seeing red, being hungry, and feeling angry" (p. 51). However, the experiential system consists of more than subconscious perception. According to the Unified Theory (Henriques, 2011; Henriques & Stout, 2012) this system includes the complex process wherein individuals reference their current position against a particular goal state, compute the amount of energy that would be required to reach that goal state, behave, and evaluate their given outcome. For example, an individual who feels anger might, on a conscious or unconscious level, trigger an approach-oriented goal of confronting the individual who angered him. At that point, his mind would calculate the amount of energy that would be required to do so as well as the likelihood that he will

be able to reach that goal. As a result of then engaging in the approach behavior, the individual would likely feel satisfied if the discussion ended in his favor but frustrated or embarrassed if he was not able to be heard, understood, and appreciated.

In psychotherapy, the experiential system is the focus of emotion-focused therapy. Emotion-focused therapy asks individuals to reflect on felt emotions, which are signals to the self that help individuals to monitor their environments and their relationships as well as to determine whether they should approach or avoid specific stimuli (Greenberg, 2002). The outward expression of emotion is an adaptive tool that allows others to perceive what individuals are feeling and to further organize their behaviors, as well. However, dysfunction occurs when individuals are not aware of their own emotions, are experiencing emotions that are secondary to more primary, or core, emotions, act impulsively on those emotions, or begin to use their own emotional expression as instruments designed to elicit specific behaviors from others, i.e. care or self-sacrificing. EFT practitioners, or emotion coaches, motivate individuals to allow themselves to feel their primary emotion, or one that lies at the core of their experience.

Making use of the aforementioned example, such an individual may choose to seek therapy for frequent angry outbursts. In this case, EFT would be used to coach him toward the realization that anger has become an old and stale emotion for him and has, in effect, been masking the primary feeling of being hurt by others. Allowing himself to feel the emotional pain and sorrow that lie at the core of his experience is hypothesized to allow the individual to feel whole and genuine (Greenberg, 2002). Further, building a frame that can hold the discomfort of primary emotions will allow for accurate readings

of an individual's environment that serve to organize his learning and behaviors as they were evolutionarily intended.

The Relational system pertains to individuals' internal networks of self-other schema, relational histories, social motivations, and relational value. The relational system is experiential in nature, as it is guided by emotional feedback, but relational behaviors and relational value are so integral to the human experience that they warrant a distinct system as well as a sophisticated guiding framework (Henriques & Stout, 2012). The Influence Matrix (IM; Henriques, 2011) provides that frame.

Recall, as discussed in an earlier section, that the IM is a multi-dimensional map of the human relationship system, which posits that human beings strive to achieve relational value by operating along 3 relational process dimensions (Henriques, 2011). Those process dimensions are power (anchored by the poles dominance and submission), love (affiliation and hostility), and freedom (autonomy and dependency). The strategies that individuals engage in are informed by their attachment histories, relational experiences, environmental contingencies, social motivations, temperament, and beliefs about self and other. If their strategies are successful and a higher degree of relational value is achieved, the IM posits that individuals will be met with positive emotions, such as happiness and a feeling of satisfaction. If their strategies are unsuccessful, however, they will be met with negative emotions, such as sadness and guilt. Accordingly, the IM is built upon the guiding principle of $P-M \Rightarrow E$, such that individuals take inventory of their current positions, compare that position to that of their reference goal (e.g. relational value), and are met with emotional outcomes (positive or negative) that serve to reinforce or punish their relational strategies.

According to Henriques and Stout (2012), the impetus for large numbers of individuals to seek psychotherapy is a perceived decrease in relational value. Such individuals present with, for example, loss of a romantic relationship, feeling undervalued at work, or feeling as though they are fighting a losing battle for recognition from others. Further, they often evidence the same unsuccessful relational patterns, feel as if they are at their wits' end, and experience confusion, helplessness, and negative affect. In such cases, the job of the clinician is to provide a conceptualization based on current relational strategies, successes and failures, and relational value as compared to what the individual had experienced in the past as well as relative to others. Clinicians then consider the individual's attachment history, presence of trauma or neglect, relational schema, and interpersonal feedback. Treatment then enfolds with the ultimate goal of increasing the degree to which the individual is truly known and valued by the self as well as by important others.

Of the major schools of thought, psychodynamic theory provides the most sophisticated method of conceptualizing the relational system. Broadly, psychodynamic theory centers on early childhood experiences, attachment and relational templates, and various motivational drives toward the fulfillment of core human needs. To this end, clinicians might employ the third wave model of schema therapy. Young's (1990; Young, Klosko, & Weishaar, 2003) schema therapy is the product of the theoretical integration of cognitive and psychodynamic models. By definition, "Schema therapy provides a new system of psychotherapy that is especially well suited to patients with entrenched, chronic psychological disorders who have heretofore been considered difficult to treat" (Young et al., 2003, p. 1). Schema therapists identify individuals' early maladaptive

schemas (EMSs), which are the product of underlying neurotic temperament, unmet core needs, and early traumatic experiences. As adults, individuals continue to act from their EMSs, which typically results in self-defeating concepts, distortions, and maladaptive relational patterns. As such, Young and colleagues' (2003) conceptualization is related to that of the maladaptive relational strategies mapped by the IM (Henriques, 2011).

Operating through the lens of the relational system, both theories posit that healing should occur with increased insight into one's own relational histories and current patterns, self-awareness, and identifying healthy strategies for obtaining one's core needs.

The Defensive system (Henriques & Stout, 2012) pertains to an individual's protection of the self from anxiety and harm through a network of distortions and avoidance strategies. Broadly, the defensive system is an adaptive mechanism for coping with distress and maintaining a sense of psychological homeostasis. In order to maintain consistency and equilibrium, individuals tend to filter their internal experiences at 2 distinct levels (see Figure 2 below). According to Henriques (2011), individuals are made up of 3 "selves." The first is the experiential self, which pertains to the experiential system described above. The experiential self also pertains to Freud's conception of the unconscious mind, which he posited contains a great deal of anxiety-provoking material that must be kept from consciousness (e.g. the ego). In this way, Henriques (2011) labeled the filter between the experiential and private selves the "Freudian filter."

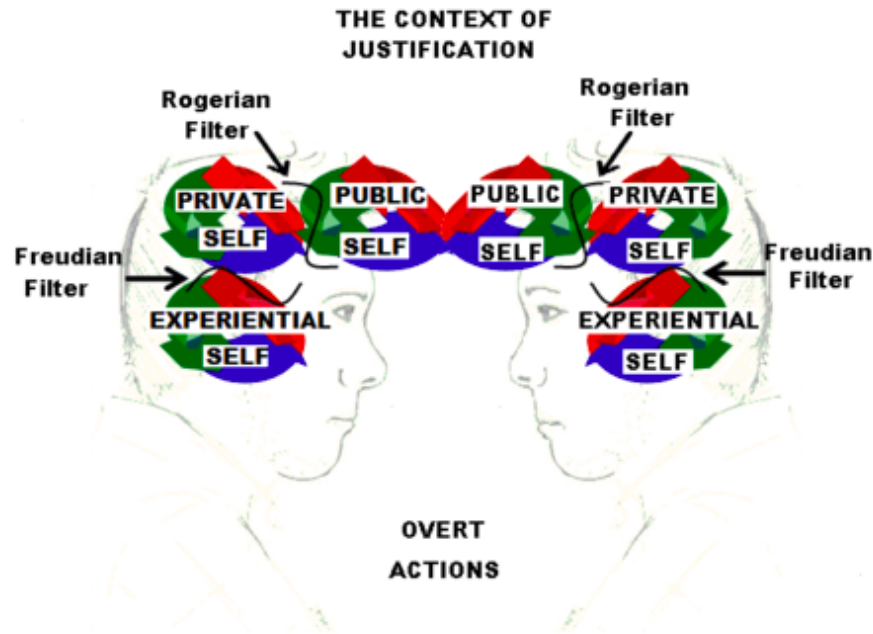


Figure X: The Tripartite Model of Human Consciousness (Henriques, 2011)

Though the Freudian filter exists to protect the self from anxiety, confusion, and harm, the defenses that individuals craft often become the very cite of dysfunction.

Traditional psychoanalytic and modern psychodynamic schools of thought have developed advanced understandings of the distinct human defense mechanisms.

Repression is the broadest category of defense and includes all methods of filtering anxiety-provoking material out of conscious awareness. In part, psychodynamic theory conceptualizes client pathology by identifying the various defenses at play, which might include, for instance, denial of ego threatening material or overcompensating by behaving in direct opposition to one's core beliefs and anxieties (i.e. reaction formation).

The 5 systems described previously are domains of character adaptation within Henriques' (2011) Unified Component Systems Approach to Conceptualizing People and Henriques' Character Adaptation Systems Theory (CAST) model. By conceptualizing

through each of these 5 lenses, individuals can be evaluated for the degree to which they are effectively adapting to their environment. Building on this notion, Henriques has since broadened his model of conceptualization. The systems of character adaptation have become key features of a more comprehensive model, which Henriques terms the “Character Wheel.” The Character Wheel model will be introduced in the following section.

From Character Adaptation System to the Character Wheel

Recall that Henriques’ (2011) Unified Component Systems approach to Conceptualizing People is a perspective that integrates various lines of theory pertaining to both psychotherapy and personality. Between the worlds of psychotherapy and personality theory, methods of understanding individuals can look vastly different. Even within the world of psychotherapy, an individual can be conceptualized according to differing domains, such as their beliefs, what they value, or the symptoms that they endorse. Within personality theory, individuals may be viewed in terms of the needs and drives that they possess or by a set of static and unchanging temperamental traits. Thus, there has been an historic lack of consensus between (as well as within) those fields.

Recently, Henriques has developed a comprehensive and inclusive model of conceptualization, which he terms the “Character Wheel” (see Figure 3 below). Featured at the center of the Character Wheel are the 5 systems of character adaptation, which allow clinicians to determine the degree to which individuals are adapting to their environment in an effective way. Recall that the 5 systems of character adaptation include the Habit System, the Experiential system, the Relational system, the Defensive system,

and the Justification system (described in detail in an earlier section). Central to the model is the notion that conceptualizing along these various domains allows for the integration of the major schools of thought in professional psychology.

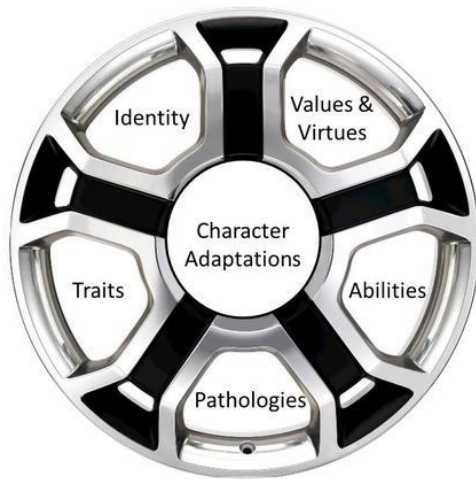


Figure 3: The Character Wheel

As can be seen, the Character Wheel also includes five spheres in addition to the central concept of character adaptation. Those areas are: traits, identity, values and virtues, abilities, and pathologies. Traits are concepts that have been highly established within the field of personality research. They have their roots in childhood temperament and are expanded upon throughout an individual's development. Traits refer to an individual's broad and general dispositions and are thought to be relatively static and unchanging across time and situations. The most established model of traits is the Five-Factor Model of personality, or "Big 5" (Costa & McCrae, 1992). The Big 5 model consists of the following traits: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. According to Henriques (personal communication, June 2, 2014), the two most important traits might be extraversion and neuroticism, which correspond to the habit and experiential systems, respectively.

Identity refers to an individual's self-concept as well as the way in which others perceive them. It is highly related to personality; however, identity can be conceptualized as an individual's own narrative of self. This includes their concept of self across situations and contexts, over time, and in relation to others.

The values and virtues domain refers to an individual's sense of morality as well as their strengths and the degree to which they make use of them. According to this model, morality can be considered reflective of an individual's methods of constructing what they believe to be right and good as well as the ways in which they justify those beliefs and moral behaviors. This concept of morality is related to Haidt's (2001) social intuitionist model. In this way, an individual's core moral value might be "remaining kind to others," which then drives and informs their behaviors as well as their beliefs about what is good for the self as well as for the world. The second construct included in this domain is that of virtues, or strengths. Individuals possess inherent strengths that occur and are utilized in varying degrees. Those strengths may be known and valued by the individual or may not yet have been identified or realized. To illustrate, Peterson and Seligman (2004) have developed a practical model of strengths and virtues, which include wisdom/knowledge, justice, temperance, transcendence, humanity, and courage.

The abilities domain consists of the set of skills that an individual possesses and the level of those skills and talents that can be used to for effective functioning in the world. Most notably, individuals are thought to possess a set level of cognitive capacity, which is referred to as the "g-factor." Modern cognitive testing can produce an intelligence quotient (IQ) that is designed to estimate the g-factor; however, in terms of adaptation to environment, a more comprehensive theory of ability was conceptualized

by Gardner (1983). Gardner's (1983) theory of multiple intelligences includes linguistic intelligence, logical-mathematical intelligence, spatial intelligence, bodily-kinesthetic intelligence, musical intelligence, interpersonal intelligence, intrapersonal intelligence, and naturalist intelligence. The concept of ability conceptualized by Henriques is inclusive of cognitive as well as functional-adaptational ability, in the tradition of Gardner (1983).

Finally, when conceptualizing individuals in terms of character, one must consider an individual's various problems and vulnerabilities. Individuals possess varying levels of distress tolerance, emotional regulation/dysregulation, problematic behavior patterns, difficulty relating to others, or intrusive cognitive or physiological experiences. Therefore, the pathologies domain allows for consideration of diagnosable conditions as well as maladaptive habitual patterns such as problematic substance use or ineffective relational strategies.

In summary, the goal of the current project was to utilize the reviewed theory and research for the development of a comprehensive way to quickly and efficiently assess character functioning and well-being in college students. The proposed assessment and formulation protocol served as a new and valuable health care tool as well as a guide for adaptive living. As was reviewed previously, other approaches have been developed based either on specific psychotherapeutic paradigms (e.g., cognitive psychotherapy) or via purely empirical and statistical analyses (e.g. Big Five, MMPI-2). The current project, however, was designed to integrate those developments into a comprehensive protocol for assessing a new sophisticated model of character domains, termed the Character Wheel. Moreover, individuals were assessed in terms of their level of well-being overall

as well as across key functional areas. In order to provide a coherent conceptualization of well-being functioning, the current study utilized the Nested Model of Well-Being as conceived by Henriques, Kleinman, and Asselin (2014).

Conceptualizing Well-being: The Nested Model

The Nested Model of Well-being (NM; Henriques, Kleinman, & Asselin, 2014) was introduced to provide structure and coherence to the field of well-being research. According to Henriques and colleagues (2014), there has been much confusion within the field of positive psychology concerning how to conceptualize well-being as a construct. Historically, research has been divided into two broad camps: hedonic and eudiamonic approaches to understanding well-being. The hedonic approach emphasizes the subjective sense of being happy, experiencing greater positive than negative emotion, and feeling satisfied with one's life. Although happiness and subjective well-being are indeed considered important to an optimal state of well-being, many researchers view the hedonic approach to represent only a narrow view. The eudiamonic approach, on the other hand, looks to an individual's moral and psychological functioning, namely the actual ability to function within their environment, level of mental health, degree of life meaning, and whether or not an individual's unique needs are being met. By nature of their definitions, the hedonic and eudiamonic approaches evaluate an individual's level of well-being from very different vantage points. The hedonic approach relies on the individual to report on their own subjective level of happiness and satisfaction and, while it is recognized that the individual remains the expert on their own functioning, the approach is inherently imprecise and difficult to quantify and compare. In contrast, an

individual would be considered high in a eudiamonic conception of well-being if they met certain criteria for living up to their full potential. To illustrate, consider the criteria that widely known researcher Carol Ryff outlined for psychological well-being: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryff, 1989 in Henriques et al., 2014). According to the perspective of the NM, both hedonic and eudiamonic approaches present crucial angles to assessing well-being; however, their scopes are inherently limited and, although complementary, are unnecessarily dichotomized. Thus, the NM was created to join these lines of research and provide a coherent integrative framework for understanding well-being within an inclusive and systemic frame.

The NM (Henriques et al., 2014; see Figure 4 below) offers a visual representation an individual's conscious state of well-being within that individual's various life domains. The model is considered “nested” due to the belief that the life domains in question exist within one another. The NM consists of four domains: the subjective domain, health and functioning domain, environmental domain, and values and ideology domain. Each will be discussed briefly below.

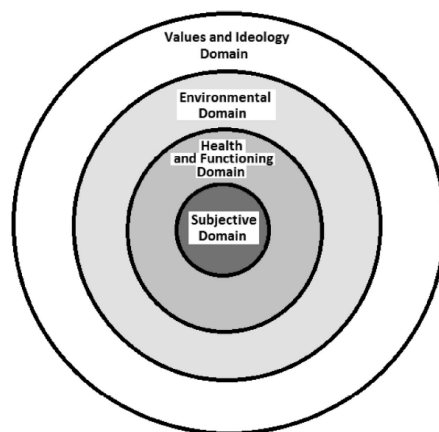


Figure 4: The Nested Model of Well-Being (NM; Henriques, Kleinman, & Asselin, 2014).

According to the Nested Model (NM, Henriques et al., 2014), well-being is assessed by an evaluator (i.e. psychologist) who considers the state of the individual according to four broad domains. The first domain exists at the center of the NM and is referred to as the subjective domain. The subjective domain consists of the individual's conscious first person experience of well-being. Within this domain, individuals reflect on their own internal state, referenced against their conceptualization of well-being, and use language to report on that state. As can be seen, the subjective domain is most closely related to the hedonic approach to well-being. However, unlike the hedonic approach, the NM does not consider subjective well-being alone to be sufficient. Instead, the NM also incorporates functional and broad systemic domains as well (a la the eudiamonic approach). The second nested level is the health and functioning domain. Within this domain lies an individual's degree of biological health and psychological functioning. Here, Henriques' Character Wheel (introduced above) provides a model for understanding. Recall that, according to the Character Wheel model, personality can be broken down into temperament and traits (i.e. extraversion, neuroticism), characteristic adaptations and identity (organized according to the 5 systems of adaptation), and adaptive potential (i.e. intelligence). According to the NM, an individual would not be said to have a high degree of well-being simply because they are extraverted and highly intelligent, per se; however, endorsing a healthy level of biological and psychological functioning as well as adaptive emotional and cognitive abilities is thought to relate to the other domains of well-being (i.e. subjective appraisal of functioning well, getting one's needs met within the given environment). Next is the environmental domain. This

domain consists of the resources in an individual's environment that are available to meet their needs. In this way, an individual would be considered higher in well-being if they lived in a physically safe setting, had sufficient nutritional opportunities, enjoyed a supportive social network, and had adequate finances. Lastly, the NM argues that inherent in evaluating an individual's level of well-being is the evaluator's own sense of what is moral and just. Therefore, the fourth domain consists of values and ideology. At the very least, this domain accounts for the evaluator's own potential biases (i.e. religious, cultural), which potentially alter their assessment of the individual's well-being and ethical state. As Henriques and colleagues (2014) illustrate, a person who is considered to have a high degree of well-being in every other respect might also be an active member of the Nazi party. According to the NM (as well as legal and ethical codes of conduct), such an individual would not be viewed as living his life in an ethical manner; therefore, the NM argues that evaluators have a moral responsibility to consider value states when assessing an overall level of well-being.

The NM (Henriques et al., 2014) presents an integrated conceptual framework for understanding well-being. Using this framework, individuals can be assessed according to self-report in the various functional domains outlined above. Moreover, there is also space for evaluators to provide their own assessment of how an individual might be doing in each of those domains. Therefore, the NM accounts for subjective and objective (evaluator rated) assessment.

Character Functioning and Well-being within a Therapeutic Assessment Frame

The nature of the proposed assessment protocol is to provide individuals with a detailed conceptualization and well-being profile (e.g. psychological check-up) within a supportive frame. In this way, individuals are not only presented with their unique profile but are invited to inform the process through dialogue and to remain involved in report generation and recommendations. As such, the protocol is designed according to the tenets of therapeutic assessment (Finn & Tonsager, 1997). In order to provide a theoretical grounding, a brief description of therapeutic assessment, including its principles and rationale, will be presented.

Therapeutic assessment (Finn & Tonsager, 1997) is based on humanistic ideals, wherein the power differential between client and examiner is reduced. The process of assessment is designed to be collaborative and clients are involved in all aspects. This might include determining goals, discussing results and potential interpretations, preparing the client's report (i.e. corroborating findings in the context of an informing or feedback session), and sharing that report with other professionals.

During testing sessions, clinicians provide clients with broad feedback and share their hypotheses. In feedback sessions, clinicians ask clients whether or not the results seem to fit for them. If the client disagrees with results or provides previously undisclosed information at that time, the clinician may choose to revise the report, as needed.

As a model, therapeutic assessment is designed to aid clients in confirming views about the self or, alternatively, to provide them with new and valuable information. As such, therapeutic assessment is designed to instill in clients a greater sense of self-

efficacy as well as feelings of being understood and accepted (Finn & Tonsager, 1997). The model is built upon the empirical finding that humans have a basic need to be seen understood, and accepted (Finn, 2008). Therapeutic assessment works to develop and instill a more coherent, accurate, and compassionate narrative concerning the client's journey, including their various struggles (Finn, 2007). As such, the current project is structured according to the principles of therapeutic assessment. In this way, the psychological check-up protocol heavily involves clients in all aspects of the assessment process, from initial contact and interview to sharing of data, conceptualization, and feedback.

Chapter Three

Developing an Assessment Protocol: The Psychological Check-Up

The goal of this assessment protocol or “psychological check-up” was to help foster awareness of key elements of character, identity, and well-being, to encourage a healthy acceptance of one’s life situation, and to foster insight that enables clients to create pathways for enhancing their adaptive living in the future. To that aim, a conceptual model of character and well-being was adapted from Henriques and Stout’s (2012) integrative conceptualization and psychotherapy framework, the CAST system, and the Nested Model of Well-being. The model was also informed by an earlier dissertation that tested Henriques and Stout’s (2012) conceptual framework in a group of psychiatric inpatients (Glover, 2013), in which a group was successfully implemented as well as carried on by staff psychologists for the three years since that time.

For the current work, a battery of assessments was developed for the purpose of evaluating individuals’ unique functioning within each of the conceptual domains. Finally, a protocol was designed to provide a systematic method of quantitative data gathering, qualitative interview, and presentation of oral and written feedback. Broadly, the protocol builds on a screening paradigm implemented as part of a recent dissertation that then translated the framework into a treatment for individuals (Mays, 2016).

Individuals were conceptualized according to their overall level of well-being and the domains of Henriques’ Character Wheel. In order to develop a battery of valid measures that would comprehensively assess functioning in each of these crucial areas, each of these domains was conceptually defined. As such, each domain will be discussed below and a rationale will be provided for the corresponding measures selected.

Assessing Well-Being

At the core of this assessment protocol is an inclusive picture of individuals' varying levels of well-being. Well-being was conceptualized in terms of subjective self-report as well as ratings by a clinical researcher. Participants self-reported their functioning across various sectors such as life satisfaction, emotional health, academics, relationships, and life purpose. For this, Henriques developed a 10-item measure of well-being that follows the Nested Model of Well-being and provides lengthy descriptions of optimal and suboptimal functioning in each of 10 areas. Individuals are tasked with rating their functioning along a 7-point scale. This snapshot of subjective functioning informed the types of questions and areas of focus within the brief interview, following the assessment phase. Ultimately, the clinical researchers then placed that subjective report of well-being within the context of their clinical observations and judgment as well as participants' own broader narrative of functioning.

Assessing Character

As we now turn toward the Character Wheel model of conceptualization, recall that the model consists of the five systems of adaptation at the center and then traits, identity, values and virtues, abilities, and pathologies on the "rim." This formulation provided the map by which assessment measures were selected.

Assessing the Five Systems of Character Adaptation

At the center of the Character Wheel are the 5 systems of adaptation, which provide an intersection between the individual and environment. As discussed at length in

an earlier section, the 5 systems of adaptation are the Habit system, the Experiential system, the Defensive system, the Relational system, and the Justification system. Each of the 5 systems will be discussed below and defined in terms of corresponding assessment measures.

The Habit system consists of reflexive actions, daily routines, and behavioral patterns. For the purpose of the current work, we focused on the areas of the Habit system that correspond to maladaptive behavioral patterns and daily routines. In this way, the Habit system was represented by four established measures, each of which was pertinent to the college-aged population. Participants responded to brief face-valid measures of sleep hygiene, eating disorder symptoms, alcohol use, and drug abuse.

The Experiential system pertains to images, impulses, emotions, and sensory experiences. For the purpose of the current work, the Experiential system was conceptualized according to individuals' affective experience. Affective experience was represented by a single broad measure of positive and negative affect and was used to guide the subsequent individual interview, wherein more detailed information about emotions and emotion regulation was gathered.

The Relational system includes relational history, needs and motivations, and relational strategies. It is a complex system that is best understood according to Henriques' (2011) Influence Matrix, which was discussed in an earlier section. As such, a measure of relational value and the relational dimensions conceptualized by the Influence Matrix was recently updated and piloted as part of the current work. In addition, it was important to understand individuals' experiences within their family of origin, including within their most important formative relationships. As such, participants were tasked

with rating both of their parents' relational behaviors, including the ways in which they experienced care and discipline. Finally, participants also responded to self-statements related to their current adult attachment style.

The Defensive system represents individuals' strategies for protecting the self from anxiety and harm. Defensive strategies range from less sophisticated, such as denial and avoidance of painful stimuli, to more sophisticated methods of distorting or filtering experiences through various levels of self (see the previous section for a lengthier discussion). For the current work, participants responded to 2 valid and reliable measures of defense and style of coping. According to one measure, they provided a self-report of their level of distress, as well as their defensiveness and methods of self-restraint. The second measure assessed perceptions of their ability to cope as well as the style of coping in which they tend to engage.

The Justification system pertains to individuals' language-based cognitions or systems of internal narration. The current work was interested in the full range of adaptive and maladaptive methods of justification; however, during the assessment phase, individuals were assessed for distorted and maladaptive cognition. As such, a short form of an established measure of dysfunctional attitudes was employed. A more inclusive analysis of adaptive and maladaptive justification was gathered during the in-person interview.

With this summary of the 5 systems of adaptation, we can move to a brief discussion of the outer rim of the Character Wheel.

Assessing Traits

The most studied and established model of personality traits is the “Big 5” model, which consists of neuroticism, extraversion, agreeableness, openness, and conscientiousness. Two valid, reliable, and brief measures of the Big 5 personality traits were selected, both of which rely on participant self-report.

Assessing Identity

In addition to assessing personality according to broad dimensions, the current work was interested in accessing individuals’ micro-level views of self. For this, an established measure of self-concept was selected, which tasks individuals with rating an extensive list of self-attributes along a Likert scale.

Assessing Values and Virtues

Participants were also assessed for their values and virtues. An understanding of that which they value helped to conceptualize the type of life that an individual would like to lead in the future as well as inform their short-term goals and objectives. The measure that was selected to assess this domain presents brief accounts of fictional individuals’ goals and wishes. Participants responded according to how much each fictional individual did or did not sound like them.

Assessing Abilities

The current project aimed to formulate a comprehensive picture of adaptive and maladaptive functioning; therefore, an assessment of participants’ level of ability in

various functional areas helped to inform that picture. For the current work, we assessed level of ability in the domains of academic and occupational functioning. Information to fill in these domains was gathered during the semi-structured interview.

Assessing Psychopathology

The current work made use of the aforementioned research on prevalent mental health problems in college students. As such, participants were assessed according to 4 measures in this area. They responded to brief screening measures for depression as well as anxiety. They also responded to a measure of characteristics consistent with personality disorders. Lastly, they self-reported current symptoms and history of attention deficit/hyperactivity disorder. It should be mentioned that the literature has found significant rates of alcohol, other substance use, and eating disorder symptoms in college students and, as such, those areas will be assessed but conceptualized within a different domain of functioning (e.g. the Habit system).

In summary, the current project offered a systematic approach to assessing well-being, character adaptation, and identity. The assessment battery consisted of established valid and reliable measures as well as a new measure of well-being that was recently developed by Henriques and a new iteration of an established measure of the relationship system. Together, results of the assessment battery provided a comprehensive picture of the whole person, all of which were anchored in Henriques' conceptual map (e.g. the Character Wheel, described in an earlier section).

Chapter Four

Method

Design Overview

The project consisted of two distinct phases: In study 1, the researchers identified measures that correspond to the domains of character and well-being delineated by the unified approach. The identified measures were then administered to a standardization sample of James Madison University (JMU) in order to develop normative data. In study 2, the researchers conducted the “psychological check-up” with a second sample of JMU students. The psychological check-up was conducted according to the proposed assessment protocol, with quantitative data referenced against the normative scores collected as part of study 1. Both phases were fully approved by the JMU Institutional Review Board before any data were collected and are described in detail below.

Study 1: Collecting Normative Data

In order to interpret the quantitative data collected via the psychological check-up, normative data was collected beforehand. The study (“The Psychological Checkup: A Normative Study”) was advertised via the JMU research subject pool, which is maintained by SONA Systems. Students interested in earning course credit for their General Psychology 101 (GPSYC101) courses signed up and participated in the study. Additionally, GPSYC101 instructors were asked to offer the study as a potential extra credit opportunity.

Procedure

For those interested in completing the study for research participation credit, potential participants were notified via the Subject Pool Announcement stating that a study was available and awarded participants with 2 hours of research credit. For those interested in completing the study for extra credit in their General Psychology 101 course, an email with the advertisement (Appendix A) and a link was provided. All GPSYC101 students received the email and only those interested voluntarily followed the links.

Participants were provided a short advertisement and web link. First, they followed a link to the informed consent (see Appendix B) and typed their name to indicate that they consented to participate. Those that indicated consent were then provided with a second link, which took them to the survey and assessment battery. Identities were collected in the form of participant names for the purpose of identifying those that should receive extra credit in the GPSYC 101 course; however, participant names were not attached to survey responses. If they provided informed consent and were eligible (i.e., a JMU college student who can provide consent), participants were asked to participate in the online assessment battery, which lasted approximately 1 hour. The online battery was made available and administered via the Qualtrics online survey system, the web link to which was provided through email.

Participants

Part one of the study contained a sample of 104 undergraduate students (56% female) enrolled at a large public university in the southeastern United States. Participant

ages ranged from 18 to 25, with a mean age of 19.0, of which 82.7% were freshmen or sophomores. The majority of participants were single (62.5%), heterosexual (88.5%) and white/non-Hispanic (82.7%). About half of the sample (54.8%) indicated that they were fairly or very religious. Greater than half of the sample indicated that their financial situation while growing up was “comfortable” (62.5%) and 21.2% reported that their families were “well to do.” Currently, 45.2% indicated that their financial situation was “tight, but I'm doing just fine” while 42.3% reported, “finances aren’t really a problem.”

Measures Chosen for the Psychological Check-Up and Completed in Study 1

Demographic Questionnaire

Participants were presented with a demographic questionnaire that was adapted from the national Healthy Minds Survey (Eisenberg et al., 2013). Participants were asked to provide their age, academic status, gender, marital status, ethnicity, highest educational attainment of either parent, level of religiosity, current financial situation, financial situation growing up, current relationship status, and sexual orientation (see Appendix C).

Assessment of Well-Being

The Henriques 10-Item Well-being Scale (H10WB; Henriques, unpublished) is a 10-item self-report measure of subjective well-being (see Appendix D). Participants rate their current (past month) functioning in 10 areas of well-being: life satisfaction, environmental mastery, emotional health, relations with others, autonomy, self-acceptance, satisfaction with academic functioning, health and fitness, sense of purpose, and personal growth. Participants respond along a 7-point Likert scale. In the current

study, H10WB total scores as well as item-level scores were interpreted. The H10WB total well-being score demonstrated good internal consistency ($\alpha = .83$).

Assessment of 5 Systems of Character Adaptation

Measures Associated with the Habit System

The Sleep Hygiene Index (SHI; Mastin, Bryson, & Corwhyn, 2006) is a 13-item self-report measure of sleep hygiene behaviors, with ratings along a 5-point scale (“always” to “never”). The measure yields a single score, which demonstrated good validity and test-retest reliability in a nonclinical sample (Mastin et al., 2006). In the current sample, the SHI demonstrated adequate internal consistency ($\alpha = .71$).

The Alcohol Use Disorders Identification Test-C (AUDIT-C; Bush, Kivlahan, & McDonell et al., 1998) is a 3-item self-report screening measure of current alcohol use. The 3-item measure is a shortened form of the 10-item original form. A screen is positive for an alcohol use disorder with a score of 4 for men and 3 for women. In the current sample, the AUDIT-C demonstrated adequate internal consistency ($\alpha = .76$).

The Eating Disorder Screen for Primary Care (ESP; Cotton, Ball, & Robinson, 2003) is a brief three-item eating disorder screen that has demonstrated sensitivity (100%) and specificity (71%) in categorizing those with eating disorder pathology. In the current sample, the ESP demonstrated an extremely low level of internal consistency that was in the negative direction ($= -.019$). Upon closer examination, this was largely due to one problematic item. Removal of that item will be discussed further in the Results section.

The Drug Abuse Screen Test-10 (DAST-10; Skinner, 1982) is a 10-item self-report screening measure of current substance use over the past 12 months. The 10-item version is a shortened form of the original 28-item version. In the current sample, the DAST-10 demonstrated adequate internal consistency ($\alpha = .77$).

Measure Associated with the Experiential System

The Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988) is a measure of the dimensions of positive and negative affect and, as such, consists of 2 separate subscales. Participants are presented with a series of labeled mood states and tasked with endorsing the degree to which they have experienced each mood state along a 5-point Likert scale (very slightly or not at all to very much). When participants were asked to endorse their experience of the given mood states “right now (that is, at the present moment”), coefficient alpha for each of the two subscales was .89 (PANAS PA scale) and .85 (PANAS NA scale) (Watson et al., 1988). Internal consistency was approximately the same for conditions in which individuals were asked to endorse mood states today, over the past few days, over the past few weeks, over the past year, and in general. With regard to external validity, the PANAS PA scale was negatively correlated with symptom distress as measured by the Hopkins Symptom Check List (-.29), and the Beck Depression Inventory (-.36) whereas the PANAS NA scale was positively correlated with the same measures of symptom distress (.65 and .58, respectively). In the current sample, internal consistency was somewhat lower than previously found, but adequate for both the PANAS positive ($\alpha = .87$) and PANAS negative ($\alpha = .78$).

Measures Associated with the Defensive System

The Weinberger Adjustment Inventory-Short Form (WAI-SF; Weinberger, 1998) is a shortened 37-item version of the original 84-item WAI. The WAI-SF contains four self-restraint subscales (impulse control, suppression of aggression, consideration for others, and responsibility) and four distress subscales (anxiety, depression, low well-being, and low self-esteem) as well as a repressive defensiveness subscale. Each item is endorsed along a 5-point Likert scale (almost never to almost always). In the current study, WAI scales demonstrated the following levels of internal consistency: Distress ($\alpha = .86$), Suppression of Aggression ($\alpha = .79$), Impulse Control ($\alpha = .66$), Consideration of Others ($\alpha = .70$), Responsiveness ($\alpha = .70$), and Repressive Defensiveness ($\alpha = .69$).

The Coping Self-Efficacy Scale (CSE; Chesney, Neilands, Chambers, Taylor, & Folkman, 2006) is a 26-item measure of perceptions of the ability to cope with one's problems. The measure yields 3 scales: use problem-focused coping, stop unpleasant emotions and thoughts, and get support from friends and family. Coefficient alpha for each of the 3 scales was .80 (get support from friends and family), .91 (use problem-focused coping), and .91 (stop unpleasant emotions and thoughts). In the current sample, the CSE demonstrated high internal consistency ($\alpha = .96$).

Measures Associated with the Relational System

The Influence Matrix Social Motivation Scale- Short Form (IMSMS-SF; Henriques, unpublished) is a 32-item self-report measure of social motives and interpersonal styles that assesses an individual's tendencies to engage in the processes of dominance, submission, affiliation, hostility, autonomy and

dependence. Items represent self-statements or imagined perceptions of what others see. The IMSMS-Short Form is a shortened and revised version of the original IMSMS. Participants rate statements along a 5-point Likert scale (Strongly Disagree to Strongly Agree). The IMSMS-SF can be found in Appendix E. All IMSMS-SF items demonstrated adequate to good levels of internal consistency: Dominance ($\alpha = .71$), Submissiveness ($\alpha = .82$), Affiliation ($\alpha = .80$), Hostility ($\alpha = .76$), Autonomy ($\alpha = .74$), Dependency ($\alpha = .73$), High Relational Value ($\alpha = .73$), and Low Relational Value ($\alpha = .66$).

The Parental Bonding Instrument (PBI) is a 25-item self-report measure of both maternal and paternal behaviors (Parker et al., 1979). Participants respond along a 4-point Likert scale (very like to very unlike). Subjects rate each parent separately. The three factors for both maternal and paternal behaviors are: care, behavioral restrictiveness and denial of psychological autonomy. In the current study, many of the PBI subscales demonstrated low reliability: PBI Maternal Care ($\alpha = .22$), PBI Maternal Overprotection ($\alpha = .58$), PBI Paternal Care ($\alpha = .35$), and PBI Paternal Overprotection ($\alpha = .68$). Removal of specific items appeared to improve internal consistency, which will be discussed in the Results section.

Measure Associated with the Justification System

Dysfunctional Attitudes Scale Short Form (DAS-SF₁; Beevers, Strong, Meyer, Pilkonis, & Miller, 2007) is a shortened 9-item form of the original Dysfunctional Attitude Scale- Form A (DAS-A; Weissman, 1979). The short form was informed by item response (IRT) analyses of the original 40-item DAS-A. Scores obtained for the

DAS-SF1 are highly associated with those of the original form ($r = .91-.93$). In the current sample, the DAS demonstrated good internal consistency ($\alpha = .76$).

Assessment of Traits

The Ten-Item Personality Inventory (TIPI; Gosling, Rentfrow, & Swann, 2003) is a brief measure of the Big 5 personality traits (neuroticism, extraversion, agreeableness, openness to experience, and conscientiousness). Participants are tasked with rating perceptions of their own personality traits along a 7-point Likert scale (disagree strongly to agree strongly). The TIPI has demonstrated high test-retest reliability (mean $\alpha = .72$). In a sample of university students, Gosling and colleagues (2003) found all 5 of the TIPI subscales to significantly correlate with the 5 corresponding scales of the Big 5 Inventory (BFI; John & Srivastava, 1999 in Gosling et al. 2003). The researchers found adequate levels of internal consistency, with the exception of that for agreeableness (.40) and openness (.45). In the current sample, the TIPI subscales demonstrated similar levels of internal consistency: Extraversion ($\alpha = .67$), Agreeableness ($\alpha = .38$), Conscientiousness ($\alpha = .37$), Emotional Stability ($\alpha = .58$), and Openness to Experience ($\alpha = .45$).

The Newcastle Personality Assessor (NPA; Nettle, 2007) is a 12-item self-report questionnaire of the Big 5 personality traits on which participants rate themselves along a 5 point Likert scale (very unlikely to very likely). The NPA yields the following subscale scores: Extraversion, Neuroticism, Conscientiousness, and Agreeableness. In the current study, the NPA subscales demonstrated the following levels of internal consistency: Extraversion ($\alpha = .52$), Neuroticism ($\alpha = .67$), Conscientiousness ($\alpha = .44$), Agreeableness ($\alpha = .61$), and Openness ($\alpha = .62$).

Assessment of Identity

The Six-Factor Self-Concept Scale (SCS; Stake, 1994) is a 36-item measure of participants' views of self. Participants respond to a series of self-attributes along a 7-point Likert scale (never or almost true of you to always or almost always true of you). The SCS yields subscale scores for the following domains of self-concept: Likeability, Task Accomplishment, Power, Vulnerability, Giftedness, and Morality.

The SCS was added after time 1 administration; therefore, normative data were not collected in the sample of JMU students. For the purpose of interpretation of time 2 participant scores, normative data from Stake (1994) were utilized for comparison.

Assessment of Values and Virtues

The Portrait Values Questionnaire (PVQ; Schwartz, Melech, & Lehnami et al., 2001) is a 40-item measure that presents short "portraits" of 29 individuals' goals and wishes. Participants are asked to consider the degree to which each individual is like or unlike them and, specifically, to rank their endorsement along a 6-point Likert scale. Ten values are measured, including power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security. The PVQ is a more concrete and easily understandable version of the original 57-item Schwartz Values Survey (Schwartz, 1992, 1996).

Assessment of Psychopathology

The Barkley Adult ADHD Rating Scale-IV (BAARS-IV) Self-Report: Current Symptoms (Barkley, 2011) is an 18-item empirically derived self-report measure of current symptoms of ADHD and report of recalled childhood symptoms. The BAARS-IV yields the following subscales, which correspond to domains of functioning thought to be impacted by adult ADHD: Inattention, Hyperactivity, Impulsivity, and Sluggish Cognitive Tempo, as well as a total ADHD symptom score. In the current project, the BAARS-IV subscales demonstrated acceptable to good levels of internal consistency: Inattention ($\alpha = .82$), Hyperactivity ($\alpha = .76$), Impulsivity ($\alpha = .66$), Sluggish Cognitive Tempo ($\alpha = .89$), and ADHD total symptom score ($\alpha = .87$).

The Patient Health Questionnaire-9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999) is a 9-item self-report measure of depression that is informed by DSM-IV criteria for a Major Depressive Episode. The measure has been shown to accurately diagnose depression in responders (85% sensitivity; 75% specificity) (Spitzer et al., 1999). In the current study, the PHQ-9 demonstrated good internal consistency ($\alpha = .88$).

The Generalized Anxiety Disorder- 7 Item (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) Scale is a 7-item self-report measure of anxiety symptoms occurring over the past 2 weeks. The measure has demonstrated high internal consistency, test-retest reliability, and validity in assessing generalized anxiety symptoms (Spitzer et al., 2006). In the current study, the GAD-7 demonstrated good internal consistency ($\alpha = .88$).

The Standardized Assessment of Personality-Abbreviated Scale (SAPAS; Moran, Leese, Lee, Walters, and Thornicroft, 2003) is an 8-item self-report measure of characteristics consistent with personality disorders. Scores above 3 accurately identify a

personality disorder in 90% of responders. Internal consistency was not calculated as the SAPAS was meant to be interpreted at the item level, with each standalone item corresponding to a discrete personality disorder.

Data Analytic Plan

Analyses were conducted in SPSS versions 21.0 and 22.0. Prior to main statistical analyses, data were examined for errors in data entry and potential outliers. Descriptive statistics were obtained for demographic variables, such as age, sex, ethnicity, academic rank, sexual orientation, and financial status.

Quantitative Analyses

Upon collecting data from the standardization sample, means and standard deviations were obtained for all measures and individual subscales. In this way, data collected for each of the Study 2: psychological check-up participants were referenced according to that of the standardization sample of James Madison University students.

Study 2: Conducting the Psychological Check-Up

This portion of the study was similarly advertised via the JMU research subject pool. The psychological check-up was advertised under the title “Who Am I and How Am I Doing?: A Psychological Check-Up Part 1.” Participants signed up for the study in order to receive course credit in their GPSYC101 courses. All procedures were approved by the JMU IRB. The first part was collected through the administration of the measures

described above, administered via an online survey program (Qualtrics). The second part was collected via face-to-face semi-structured interview with a researcher.

Procedure

The online assessment battery

Participants were provided a short advertisement and web link. First, they followed a link to the informed consent (see Appendix A). Upon consenting to participate in the study, participants typed their name and a self-generated 4-digit code. The generation of subject codes was to ensure that the data could be analyzed in a confidential manner.

A code sheet with participant number and other assessment data was kept in a password protected electronic file. When the research is complete, the identity-linking code sheet will be destroyed. Data collected from the web survey were downloaded, stored in a password-protected Excel spreadsheet, and saved in the principal investigator's N:drive folder.

Those that indicated consent were provided with a second link, which took them to the survey and assessment battery. Identities were collected in the form of participant 4-digit codes for the purpose of identifying them for their in-person interview; however, participant names were not attached to survey responses. If they provided informed consent, they were then taken to the online assessment battery, which lasted approximately one hour.

Recruitment for the Psychological Check-Up Interview and Feedback Phases

All participants who completed the online assessment battery were contacted via email (see standardized email contact message in Appendix F). The email message first thanked participants for submitting their responses to the online assessment battery. Next, they were invited to participate in Phase 2 of the study, which would be worth 2 additional research credits, in addition to the 1 credit earned for completing the online assessment battery. Participants who did not respond to the email invitation were contacted 3 times before the researchers assumed that they were not interested. Those participants who did respond and indicate interest were asked to provide all of their availability over the next 2 weeks. Upon receiving that information, the researchers looked for a match between the participant's availability and that of one of the researchers. Each participant was then contacted again with a 1-hour appointment time and provided with directions to the site of the interview. They were also informed that they would need to schedule a feedback session for approximately 1 week after the scheduled interview. Regarding inclusion, all participants who indicated interest and provided available time slots were scheduled to meet with a researcher.

Additional Assessments in Part 2: The Psychological Check-Up

Semi-Structured Interview

The Semi-Structured Interview (Appendix G) is designed to assess the key pieces of a person's life and functional repertoire. The interview fosters the construction of a personal narrative based on the following areas: personal history, strengths and limitations, and areas that tend to result in neurotic or maladaptive patterns, which in turn informs how

each individual's story might unfold in a more adaptive way in the future. Typically, the semi-structured interview requires approximately 50 minutes. It is semi-structured in the sense that the interviewer is guided by domains and certain questions are offered as suggestions, but it is not designed to be delivered in a specific or rigid manner.

Providing Feedback

A licensed clinical psychologist reviewed the results of the Semi-Structured Interview and self-report measures and worked with the graduate student researchers to provide a write-up of the participants' well-being profile and character adaptation systems, which together constituted the psychological check-up. These feedback sessions lasted approximately 30-45 minutes. Each participant was provided with a list of individually tailored recommendations, including contact information for counseling services in the Harrisonburg area if appropriate.

Feedback Questionnaire

At the end of their feedback sessions, participants completed a 5-item feedback questionnaire that was developed for the current project (see Appendix H), wherein they were given an opportunity to share their own experience. Such qualitative data were used to inform an overall impression of the utility of employing the current approach in a college student population.

Follow-Up Feedback Questionnaire

Finally, participants were contacted via email approximately 2 weeks after their feedback sessions, with the goal of once again assessing participant experiences with the protocol and information shared as well as to look for any change in response (e.g. from a positive experience to a negative experience such as increased anxiety). The Feedback Questionnaire- Short-term Follow-Up (see Appendix I) contained 4 items that assessed participant views of their report's accuracy and meaning as well as any positive and/or negative reactions that they might have had. These follow-up feedback responses were not used in any of the qualitative analyses, but instead were used to assess participant safety and potential levels of distress following their informing sessions.

Study 2 Participants

Study 2 first consisted of completion of the online assessment battery followed by recruitment of those participants to complete the rest of the psychological check-up protocol. Seventy-five participants (67% female) completed the online battery. Participant ages ranged from 18 to 31, with a mean age of 19.7, of which 52.0% were freshmen. The majority of participants were single and not in a relationship (70.7%), heterosexual (98.7%) and white/non-Hispanic (78.7%). About half of the sample (48%) indicated that they were fairly or very religious. Greater than half of the sample indicated that their financial situation while growing up was "comfortable" (56.0%) and 29.3% reported that their families were "well to do." Currently, 48.0% indicated that their financial situation was "tight, but I'm doing just fine" while 46.7% reported, "finances

aren't really a problem." In this sample, 41.3% reported having a parent that held a graduate degree.

Of those 75 individuals who completed the online assessment battery, 10 individuals could not be contacted for an interview as they provided a self-generated 4-digit code but did not provide a name. In total, 65 individuals were contacted via email to schedule an appointment with a researcher, in exchange for two additional research credits (see email invitation in Appendix F). Participants were contacted up to three times to schedule an appointment. Twenty-two participants expressed interest in meeting with a researcher, of which 19 actually engaged in the interview process. All of the 19 participants who engaged in the interview went on to complete the informing session and provide feedback about the experiences with the psychological check-up process.

In total, 19 participants completed the entire psychological check-up protocol, which included the interview and feedback phases. There were no statistically significant differences between this group ($n = 19$) and that of the total number who completed the online battery in part 2 of the current study ($n = 75$). In the sample of 19 psychological check-up participants, 73.7% were female. Participant ages ranged from 18-24 with a mean age of 19.9, of which 42% were freshmen. The majority of participants were single (68.4%), white/non-Hispanic (78.9%), and 100% were heterosexual. Approximately half of the sample (47.4%) reported that they were fairly or very religious. Greater than half of participants indicated that their financial situation growing up was "comfortable" (63.2%) and 36.8% reported being "well to do." Greater than half (52.6%) indicated, "finances aren't really a problem." More than half of participants (52.6%) reported having a parent that held a graduate degree.

Analyses of Feasibility and Utility

As the current project represented a new protocol development design, research questions concern the feasibility and utility of implementing that assessment protocol. Feasibility was determined according to the following areas: a) development of a “psychological check-up” protocol, grounded in Henriques’ conceptual models of character and well-being; and b) implementation of that assessment protocol design in at least 20 university students.

Utility was examined across the following three areas: a) assessment of each distinct component’s clinical utility; b) overall accuracy of the conceptual feedback report, as evidenced by participant response; and c) level of utility and meaning garnered as a result of the psychological check-up experience, as evidenced by participant and informed by clinical and professional judgment.

Chapter Five

Results

The results from the study are organized according to distinct aspects of the larger protocol development and implementation. Specifically, part one results are presented, including normative means and standard deviations for the standardization sample. Part two results are presented in support of answering five distinct, interrelated areas of inquiry. Those five questions serve to evaluate the main research objectives, namely examination of feasibility and utility of the assessment protocol. To that end, the following data are presented: 1) quantitative assessment data and clinical interpretation as well as 2) behavioral observations, 3) the experience of delivering the feedback, 4) participants' own evaluations of the psychological check-up process, and 5) the researchers' professional judgment and reactions to the process.

Results of Study 1

Collection and Examination of Normative Student Data

Study 1 consisted of: a) development of a computer-administered integrative assessment battery that yields a comprehensive map of human functioning; and b) use of that battery to collect normative data in a sample of local university students.

A sample of 104 university students completed the online psychological assessment battery ($n = 104$, 56% female, mean age = 19 (range 18 – 25), 62.5% single). Measures included as part of the online battery are described in an earlier section (Chapter 4). Raw data were downloaded and explored via SPSS versions 21.0. and 23.0. Sample means and standard deviations are presented below in Table 1.

*Table 1:**Means and Standard Deviations for Psychological Check-Up Assessment Measures*

Variable	<i>M</i>	<i>SD</i>
H10 Overall Mean Well-Being	51.94	7.96
#1-Satisfaction w/ Life	5.35	1.05
#2-Mastery of Enviro., resources, coping	4.95	1.25
#3- Emotional Health	5.00	1.25
#4-Relationships w/ others	5.72	1.11
#5-Sense of autonomy	5.33	1.35
#6-Self-Acceptance	5.06	1.45
#7-Academic Functioning	4.74	1.42
#8-Health & Fitness	4.79	1.38
#9-Purpose in Life	5.41	1.27
#10-Personal Growth	5.53	1.08
PANAS Positive	29.70	5.85
PANAS Negative	19.04	5.21
BAARS-IV Inattention	15.26	4.08
BAARS-IV Hyperactivity	8.48	2.97
BAARS-IV Impulsivity	6.02	1.92
BAARS-IV Sluggish Cognitive Tempo	17.16	5.88
BAARS-IV Total ADHD Score	29.55	7.38
PHQ-9 Depression Screen	6.54	5.59
GAD-7 Anxiety Screen	5.55	4.62
PBI Maternal Care	15.44	3.88
PBI Maternal Overprotection	17.36	4.88
PBI Paternal Care	17.13	4.73
PBI Paternal Overprotection	19.42	4.93
Coping Self Efficacy	180.68	39.65
WAI Distress	2.56	0.68
WAI Suppression of Aggression	4.05	0.90
WAI Impulse Control	3.85	0.73
WAI Consideration of Others	3.75	0.64
WAI Responsibility	4.18	0.72
WAI Repressive Defensiveness	3.27	0.48
DAS Mean Dysfunctional Attitudes	2.17	0.47
TIPI Extraversion	4.59	1.57
TIPI Agreeableness	5.01	1.12
TIPI Conscientiousness	5.23	1.12
TIPI Emotional Stability	4.82	1.28
TIPI Openness to Experiences	5.22	1.14
Newcastle Extraversion	2.98	0.99

Newcastle Neuroticism	2.90	0.94
Newcastle Conscientiousness	3.67	0.88
Newcastle Agreeableness	4.08	0.76
Newcastle Openness	3.13	1.01
SAPAS Personality Symptom Count	2.85	1.43
AUDIT total Score	4.34	3.18
ESP Abnormal Eating Symptom Count	1.54	0.92
DAST-10 Total Score	1.28	1.82
SHI Sleep Hygiene	2.81	0.50
IMSMS-SF Dominance	3.16	0.78
IMSMS-SF Submissiveness	2.50	0.77
IMSMS-SF Affiliation	4.01	0.68
IMSMS-SF Hostility	2.49	0.82
IMSMS-SF Autonomy	3.25	0.71
IMSMS-SF Dependency	3.01	0.73
IMSMS-SF High Relational Value	4.00	0.56
IMSMS-SF Low Relational Value	2.56	0.67

Note: (n=104)

Examination of participant data revealed that overall well-being was in the “somewhat high to high” range ($M= 51.94$, $SD= 7.96$). According to Henriques, individuals scoring at that level are expected to be functioning well across domains, to be resilient, and not currently in need of mental health services. A closer look at ratings across specific domains revealed mean scores that ranged from “mixed to somewhat high” (Mastery of Environment/Coping, Emotional Health, Academic Functioning, Health & Fitness) to “somewhat high to high” (Satisfaction with Life, Relationships with Others, Sense of Autonomy, Self-Acceptance, Purpose in Life, Personal Growth).

Next, participants’ trait functioning, identity, and self-concept were examined and interpreted tentatively as suggested by brief self-report measures. Participants were administered two measures of the “big 5” personality traits (TIPI and Newcastle Personality Inventory). Across the two trait functioning measures, our sample appeared to

endorse medium-high scores for 3 of the personality traits: conscientiousness, openness, and agreeableness.

Next, scores for mental health screening measures were examined. There was an overall mild level of depression (PHQ-9, $M = 6.54$, $SD = 5.59$) and similarly mild level of anxiety (GAD-7, $M = 5.55$, $SD = 4.62$). Closer examination of the distribution of scores revealed that 20% of participants endorsed at least moderate depression (PHQ-9 > 10) and 3% of participants endorsed severe depression (PHQ-9 > 20), 19% endorsed at least mild anxiety (GAD-7 > 5) and 5% endorsed a moderate level of anxiety (GAD-7 > 15). Results of a screening measure for adult ADHD symptoms suggested that 8.9% of our sample appeared to screen positive for ADHD (BAARS-IV, $M = 29.55$, $SD = 7.38$).

Next, variables pertaining to each of the 5 systems of character adaptations were examined (habit, experiential, relational, defensive, and justification). First, participants' alcohol use and substance use as well as sleeping and eating habits were examined. The mean alcohol use score indicated a positive screen for problematic alcohol use (AUDIT-C; $M = 4.34$, $SD = 3.18$), with 51.6% of our sample endorsing a problematic level of drinking. Results suggested a low level of illicit substance use ($M = 1.28$, $SD = 1.82$), with 8% endorsing moderate use and 5% endorsing substantial use of substances. A brief measure of sleep hygiene revealed moderate to somewhat poor sleep hygiene ($M = 2.81$, $SD = 0.50$). A screening measure for problematic eating behaviors associated with eating disorders (anorexia nervosa, bulimia nervosa, and binge eating disorder) revealed a negative screen, according to recommended cut offs (ESP, $M = 1.54$, $SD = 0.92$). With regard to the experiential system, results revealed that participants endorsed average levels of both positive ($M = 29.70$, $SD = 5.85$) and negative affect ($M = 19.04$, $SD = 5.21$).

With regard to the defensive system, our sample appeared to experience an average level of distress as compared to original normative data (WAI Distress, $M = 2.56$, $SD = 0.68$) and, as methods of coping, tended most often to suppress aggression ($M = 4.05$, $SD = 0.90$) and take on excessive responsibility ($M = 4.18$, $SD = 0.72$). Further, participants endorsed high average coping self-efficacy ($M = 180.68$, $SD = 39.65$). Participants' relational systems were assessed according to interpersonal dimensions mapped by the Influence Matrix. Broadly, sample mean scores revealed high endorsement of high relational value ($M = 4.00$, $SD = 0.56$) and moderate endorsement of low relational value ($M = 2.56$, $SD = 0.67$). On the power dimension, participants endorsed moderate dominance ($M = 3.16$, $SD = 0.78$) and submissiveness ($M = 2.50$, $SD = 0.77$), with the former being higher. On the love dimension, participants endorsed more affiliation ($M = 4.01$, $SD = 0.68$) than hostility ($M = 2.49$, $SD = 0.82$). On the freedom dimension, results were moderate for both autonomy ($M = 3.25$, $SD = 0.71$) and dependency ($M = 3.01$, $SD = 0.73$). Results of a measure assessing parental bonding revealed that, on average, participants rated both parents to be significantly overprotective (PBI Maternal Overprotection, $M = 17.36$, $SD = 4.88$; PBI Paternal Overprotection, $M = 19.42$, $SD = 4.93$) and lower in overall caring (PBI Maternal Care, $M = 15.44$, $SD = 3.88$; PBI Paternal Care, $M = 17.13$, $SD = 4.73$). Finally, with regard to the justification system, participants endorsed an average level of dysfunctional attitudes, according to a brief version of the DAS ($M = 2.17$, $SD = 0.47$).

The normative data described above was used to inform interpretation of student data collected in study 2. In this way, student participants were compared to their peers' self-rated functioning in each of the included domains.

Results of Study 2

Study 2 of the Psychological Check-Up study consisted of recruiting participants to complete the online assessment battery, interpreting results using the study 1 normative data that was previously collected, conducting the semi-structured interview, generating a conceptual report for each participant, conducting the informing sessions, and obtaining feedback from the participant at that time as well as two weeks later. A sample of 75 participants completed the online assessment battery ($n = 75$, 67% female, mean age = 19.7 (range 18 – 31), 70.7% single). Participants were recruited from that sample to engage in the interview and feedback phases (e.g. the Psychological Check-Up protocol) ($n = 19$, 73.7% female, mean age = 19.9 (range 18 – 24), 68.4% single).

Results are reported on the following domains: 1) Comparison of the samples to determine reliability of norms; 2) Determine the feasibility and ease with which individuals would complete the full interview process; 3) Comparison of quantitative measures between those who completed the interview versus those who did not; 4) A description of four cases to provide a sample of the process; 5) A summary of qualitative feedback regarding the accuracy and utility of the evaluation process and 6) A reflective assessment of the clinical utility of the psychological checkup from the vantage point of the researchers.

Comparison of the Samples

Analyses were conducted to examine for differences between the participants in part 2 ($n = 75$) and those who participated in the part 1 standardization sample ($n = 104$). An independent samples t -test revealed that the two samples differed by age ($t(177) = -$

3.48, $p < .01$), specifically with sample 1 being younger in age ($M = 18.96$, $SD = 1.11$) than sample 2 ($M = 19.73$, $SD = 1.85$). Additionally, a Chi-Square test of independence revealed that the two samples differed by year in college ($\chi^2 (3, N = 179) = 9.42$, $p = .02$) with more sample 1 students being freshmen or sophomores than those of sample 2, which were more evenly distributed. With regard to dependent variables, an independent samples t -test revealed that the two samples differed on two dependent variables. There was a significant difference in the scores for alcohol use ($t (161) = -2.64$, $p < .01$), with sample 2 endorsing greater use than sample 1 ($M = 4.83$, $SD = 2.74$; $M = 3.71$, $SD = 2.64$). There was also a significant difference in the scores for BAARS impulsivity ($t (174) = -2.39$, $p = .02$), with sample 2 endorsing greater impulsivity than sample 1 ($M = 6.71$, $SD = 2.06$; $M = 5.99$, $SD = 1.89$).

Next, analyses were conducted to examine for differences between participants who completed the online assessment battery in part 2 but did not complete the entire psychological check-up battery ("non-completers," $n = 75$) and those that went on to complete the entire psychological check-up protocol ("completers," $n = 19$). Results of an independent samples t -test revealed that there were no statistically significant differences between the samples on any of the demographic variables. Results of an independent samples t -test revealed that there were statistically significant differences between samples on 3 of the dependent variables measured as part of the psychological check-up battery. Specifically, there was a significant difference between groups in the score for the self-concept scale Power ($t (69) = -3.21$, $p < .01$), with the non-completers scoring higher ($M = 31.02$, $SD = 6.42$) than the completers ($M = 25.00$, $SD = 7.68$). There was also a statistically significant difference between groups in the score for the self-concept

scale Giftedness ($t(70) = -2.12, p = .04$), with the non-completers scoring higher ($M = 25.32, SD = 4.85$) than the completers ($M = 22.16, SD = 7.25$). Finally, there was a statistically significant difference between groups in the score for the IMSMS scale Autonomy ($t(73) = -2.34, p = .02$), with the non-completers scoring higher ($M = 3.21, SD = .65$) than the completers ($M = 2.78, SD = .86$).

Examination of the Psychological Check-Up Protocol: Feasibility and Utility

Part 2 of the current study sought to evaluate the feasibility and utility of a new “psychological check-up” therapeutic assessment protocol. Each criterion will be introduced briefly and then evaluated at length in a later section, following 4 in-depth participant case studies. Feasibility was examined according to successful implementation in the following two areas: a) development of a “psychological check-up” protocol, grounded in Henriques’ conceptual models of character and well-being; and b) implementation of that assessment protocol design in at least 15 university students. Utility was examined across the following three areas: a) assessment of each distinct component’s clinical utility, which includes assessment interpretation, in vivo interview, and feedback session; b) overall accuracy of the conceptual feedback report, as evidenced by participant response; and c) level of utility and meaning garnered as a result of the psychological check-up experience, as evidenced by participant and informed by clinical and professional judgment.

Case Studies of Psychological Check-Up Participant Experiences

In order to convey the results of the psychological check-up project, 4 individual cases were selected and are presented below. Through the following cases, the reader is presented with an in-depth description of the process from the point at which each participant completed the initial online assessment battery to their feedback session and written reactions to the psychological check-up experience. All participant names and other personal identifying information have been changed in accordance with the “Safe Harbor” method of de-identification suggested by the U.S. Department of Health and Human Services Office for Civil Rights (HHS OCR; 2012) Following the 4 case studies, qualitative results will be provided in service of examining feasibility and utility of the current protocol.

Case #1: “Anna”

Participant number 4280 (henceforth referred to as ‘Anna’) completed the Psychological Check-Up Assessment battery for 1 credit toward her General Psychology 101 research requirement. The study was advertised under the title, “Who Am I and How Am I Doing?: A Psychological Check-Up Part 1.” Upon completion, she was promptly contacted and invited to participate in Part 2 of the study, which was to be worth 2 additional research credits. In the meantime, Anna’s assessment data were downloaded, scored, and converted to z-scores using the JMU normative data for each of the variables of interest.

According to typical procedure, Anna’s overall level of well-being was considered first. Her overall well-being score constituted $z = -0.62$, which was considered average as compared to her peers. Examination of specific well-being items revealed that

she rated her satisfaction with health and physical fitness lowest (a score of 3 out of 7, corresponding to “somewhat low”) and that the rest of her well-being domains were rated neutral to highly satisfactory (at least a 4 and above). In particular, she rated her sense of autonomy, self-acceptance, and sense of personal growth as 6/7.

Next, Anna’s unique systems of adaptation were considered, beginning with the Habit system. Her data revealed a low endorsement of alcohol as well as other substance use. She also indicated that her sleep hygiene was quite good, and there did not appear to be any problems with eating behaviors. With regard to the Experiential system, her endorsement of positive affect was $z = -0.63$, which was considered average; however, her report of negative affect was $z = -1.16$, which was significantly below average as compared to her peers. This pattern suggested that she was potentially underreporting or under-experiencing both types of affect, which could have been indicative of defensiveness or emotional numbing, in general. In consideration of that hypothesis, her Defensive system was examined next. Her self-report indicated an average level of distress, as compared to her peers. In particular, her profile suggested that she might manage her distress by overregulating her impulses ($z = 1.58$) and taking on excessive responsibility ($z = 1.14$). Further, her self-report indicated that she felt slightly less than confident in her coping abilities ($z = -0.95$).

Anna’s Relational system was considered next. Her relational profile suggested a style that was not particularly dominant but certainly not submissive, much more autonomous than dependent, about average in affiliation with others, and not at all hostile. That being said, her profile appeared to be similar to those of typical JMU students except for the findings that her level of submissiveness and hostility were

significantly lower than typical ($z = -1.95$ and -1.82 , respectively). Further, her levels of high and low relational value appeared average, as compared to her peers.

Developmentally, it appeared that her mother was experienced as very caring ($z = 1.91$) and about an average level of overprotection, as compared to her peers ($z = 0.51$). Her father's level of care for her was experienced as about average ($z = 0.72$) and he was not very overprotective ($z = -0.85$). Finally, her Justification system was examined, which consisted of a largely average level of dysfunctional attitudes ($z = -0.60$).

Anna's trait profile was then considered. Taken together, results across two measures of big 5 personality factors revealed a tendency toward introversion (Extraversion: $z = -2.29$ and -1.49), agreeableness ($z = 1.33$ and 0.55), conscientiousness ($z = 1.13$ and 0.94), and approximately average openness as compared to other JMU students ($z = 0.68$ and 0.37). Her neuroticism dimension differed between the two personality measures, with one indicating that neuroticism was average ($z = 0.11$) and one indicating a lower level of neuroticism (emotional stability (opposite of neuroticism) $z = 0.92$). Next, her self-concept was examined. According to self-report, it appeared that Anna considered herself to be within the realm of average for all self-concept factors, including likeability, task accomplishment, power, vulnerability, giftedness, and sense of morality.

Lastly, Anna's mental health and potential levels of pathology were considered. According to brief screening measures, she endorsed minimal anxiety but a mild level of depression (PHQ-9 total = 8). She did not endorse any of the dimensions of ADHD and, in fact, she scored significantly lower than her peers on the impulsivity subscale ($z = -1.05$).

Shortly thereafter, Anna participated in an interview. She arrived on time for the scheduled interview. She was well groomed and casually dressed. She self-identified as an African American female and was of average height and was somewhat overweight. She was cooperative and appeared to have little difficulty with disclosure. Her eye contact was variable, as she tended to look away when considering answers to more personal questions. Her speech appeared to be of above average volume and speed. Based on her vocabulary and clinical judgment, she appeared to be of above average intelligence. Affect was positive throughout the interview and, during discussion of negative events, she winced but did not display other signs of negative affect.

During the interview session, Anna received psychoeducation about the process of the Psychological Check-Up and what was to come. She was also given an opportunity to ask questions. Following that, the clinical researcher provided her with a description of well-being and asked Anna to comment on how she believed she had been faring across areas of well-being functioning. As Anna shared her description of feeling “happy overall” and her success in classes, the researcher shared with her that, indeed, her well-being results were congruent with that description.

Anna was then given more space to share her narrative of how various aspects of her life had been going. The researcher followed Anna’s lead and used specific questions suggested by the Semi-Structured Interview to access greater detail in each of the domains. Through her descriptions, an overall pattern began to emerge. Anna presented as an achievement-oriented and driven individual who seemed to spend a great deal of time and effort on her studies. She was a self-described introvert (which was corroborated by her results) and seemed to spend a great deal of her time alone. It appeared that she

did not have many deep or intimate relationships in her life and had not made close friends on campus. Thus, a related pattern began to emerge as well. It seemed that while Anna appeared to favor spending time alone over interacting with others on a meaningful level, it also might be that she did so out of defensive avoidance, rather than just due to a personal preference for solitude. When the researcher shared that question, there was a turning point in the interview.

As Anna described her family history, her current patterns seemed to have a developmental origin. When Anna was in 4th grade, her parents divorced, she moved, and lost her established friend base. What was worse was that she now spent nearly all of her non-school hours at home with her mother, whom Anna described as preoccupied with her own needs. Anna's mother openly criticized her body shape and weight and was seemingly never pleased with Anna's behaviors in general. Based on Anna's descriptions, it appeared that this might have led to her developing her own internal critic and adopting perfectionistic standards for herself. This might also have set the stage for her defensive isolation and distancing behavior.

During the course of the interview, the researcher tentatively called attention to certain patterns as they emerged. In response, Anna appeared to feel a bit surprised before quickly acknowledging her vulnerabilities. Essentially, she showed an ability to meet the clinical researcher in a place of vulnerability. In that state, she also acknowledged that she did have a desire for closer friendships and to allow important others to truly get to know her.

After the session, the researcher compiled all of the interview data and considered the ways in which her narrative provided a context for her assessment results. Taking

everything into consideration, the researcher then compiled an interpretive report of Anna's well-being and character functioning (see Appendix J for complete report). Following the "Major Findings," a crucial part of the report in this case was the "Brief Historical Narrative of Key Events." For someone like Anna, it was important for the report to highlight her adaptive strategies. In response to criticism, Anna compensated by working hard and performing well. In so doing, she had identified a passion and a career path and had been working toward her own self-identified goals. Moreover, she presented as a very positive and upbeat individual. However, there were clearly vulnerabilities and defenses at work to regulate underlying distress, especially in regards to relational needs. The results of the interview suggested that she had developed a bit of a counter-dependent style, and there appeared to be some strategies of defensive separation from others, hyper-autonomy, and achievement-oriented anxiety. Therefore, the brief historical narrative portion of Anna's report was constructed in such a way as to tell her story in chronological order, using her own terminology wherever possible, and highlighting the ways that she evolved as a result of her circumstances, which represented both adaptive and maladaptive components. Additionally, the researcher chose to present some of the more difficult material in a more tentative manner. For this, the report included brief third person accounts of what might be possible "for some people." To illustrate an example that captures all of these components, the following excerpt is presented from Anna's psychological check-up report:

While you have always known that your mother cares for you, you also shared that she tends to prioritize her own needs and to react with negative emotion at times. This was particularly difficult for you during adolescence. At that time, you shared that your mother showed frequent irritability and criticism. Potentially, this might provide an explanation for the strategies that you developed at that time, including making sure that you received good grades, becoming very clean, and

also beginning to criticize your own body. For some people, feeling as though they cannot connect with important others motivates them to work very hard to please and impress those individuals. In this way, they hope that they might receive the love and understanding that they feel they are missing. This refers to the core need for relational value, which is the degree to which we feel important others know, understand, and value us for who we really are.

Two weeks after the initial interview, Anna returned for a feedback session, during which the researcher presented a written copy of the report and engaged in a discussion of the major findings, conceptual narrative, and recommendations. Anna received the information well, often commenting that it felt “strange to see it all written out on the paper” but that she felt she was learning a great deal about herself through the process. She appeared very motivated to work on her anxiety and perfectionistic standards for herself. She also discussed the pervasiveness of her sense of guilt, which she acknowledged was also used as motivation to succeed. She shared a desire to change the way that she interacted with others by disclosing some of her struggle, voicing occasional needs for support, and attempting to meet them on an emotional level. For this, she stated, she was going to need help. While Anna was clearly motivated to change, she was unsure of how to begin. Her insight and desire to change were heavily reinforced.

Anna was then presented with several recommendations. It was explained that all participants were presented with information for psychotherapy services. In her case, taking into consideration her motivation and interest in therapy, treatment was suggested. In addition to therapy, she was also provided with a self-help recommendation: Kashdan and Biswas-Diener’s (2014) *The Upside of Your Dark Side*. This resource was selected for Anna because it was thought that she could benefit from Kashdan and Biswas-

Diener's (2014) central teaching: That individuals can truly benefit and learn from their negative emotions (e.g. anger and sadness) in addition to positive emotions and that they should work to adopt a wider range of emotional expression, inclusive of negative feeling states. Finally, Anna was presented with additional self-help material in the form of suggested step-by-step guides to "become in touch with your negative emotions," "alter the way you regulate emotions," and "recognize your need for relational value." (see Recommendations as part of the full report in Appendix J).

At the end of the session, Anna provided written feedback about the psychological check-up process. Anna's feedback indicated that the process helped to add to her sense of knowledge about herself: "...I liked that it was very personalized based on my experiences. It really allowed me to connect some of my weak points to particular times/events from the past, and allow me to understand ways to grow."

Finally, Anna continued to voice increasing insight and motivation to change, which was evident in her answer when asked how she might use the information that was provided to her. To that, Anna responded:

I think by recognizing the areas in which I need help, I will be able to figure out the best suitable solutions for myself and move forward with helping myself internally, as well as seeking help from other sources. This experience has made it easier for me to talk to others and more open to the idea of therapy, so I will definitely be willing to look into that!"

Case #2: "Barb"

Participant number 1914 (henceforth referred to as 'Barb') completed the Psychological Check-Up Assessment battery for 1 credit toward her General Psychology 101 research requirement. Upon completion, she was promptly contacted and invited to participate in Part 2 of the study, for 2 additional research credits. In the meantime,

Barb's assessment data were downloaded, scored, and converted to z-scores using the JMU normative data for each of the variables of interest.

According to typical procedure, Barb's overall level of well-being was considered first. Her overall well-being, according to the H10WB, was within the average range as compared to her peers ($z = -0.37$). Her ratings across well-being domains were varied, however, with four domains of functioning rated very highly (6/7), including relationships with others, sense of autonomy, purpose in life, and personal growth, and the remaining areas in moderate satisfaction range, with one exception. Barb rated her emotional health a 3/7, which corresponded to $z = -1.60$. That being the case, the researcher then looked to results of her mental health screening measures, which indicated mild levels of both depression and anxiety. However, ratings of her affective functioning, according to the PANAS, were in the average range, as compared to other JMU students. Her results were indicative of mild impulsivity and hyperactivity as compared to other JMU students ($z = 1.03$ and $z = 0.85$, respectively) but her total level of ADHD symptom endorsement was considered average ($z = 0.45$).

The researcher then looked to the data to understand how much distress Barb was reporting, what defensive strategies she might have been using, and how effective she believed her coping to be. Results from the WAI indicated an average level of distress, as compared to her peers ($z = 0.40$). Her ratings for specific defensive strategies indicated that she tended to take on extra responsibility ($z = 1.14$) and suppress aggression ($z = 1.06$). Overall, she rated her coping self-efficacy to be average, as compared to other JMU students ($z = 0.18$).

In order to get a broader picture, the researcher looked to Barb's big-5 personality profile. Results across the two personality trait measures were significantly different, making interpretation difficult. Results of the TIPI indicated that Barb might be an agreeable ($z = 1.42$) and conscientious person ($z = 1.58$) and that she was significantly lower than her peers on emotional stability ($z = -1.03$). Results of the Newcastle were unremarkable as they revealed average scores for all 5 dimensions in the context of JMU normative data; however, using suggested Newcastle cut-off scores, her rating for agreeableness was considered to be high (subscale score = 9/10). Finally, Barb's ratings on the Six Factor Self-Concept scale revealed that she believed herself to be a virtuous person ($z = 1.50$). Her ratings suggest a high average endorsement of likeability and good work habits ($z = 0.82$ and $z = 0.79$, respectively).

Barb's Relational domain was considered next. On the IMSMS-SF power dimension Barb's ratings indicated a tendency toward submissiveness rather than dominance. On the love dimension, her scores indicated significant affiliation with others rather than hostility ($z = 1.46$ and $z = -.90$, respectively). On the freedom dimension, Barb's ratings were average for both autonomy and dependency, as compared to her peers. Finally, Barb's results indicated an average endorsement for high relational value and a significantly elevated endorsement of low relational value, as compared to her peers ($z = 1.03$). Taken together, results suggested that Barb might give up some of her personal power in favor of conforming to the needs of others or a group. Her level of high relational value also suggested that her strategies were in some ways effective, but her level of low relational value indicated that her needs were not being adequately met, though she did not appear in touch with any hostility in response to that.

With regard to the Habit domain, Barb's scores indicated significantly poorer sleep hygiene, as compared to her peers. Her ratings were indicative of low average alcohol use as compared to her peers and no endorsement of substance use. Her responses were not suggestive of abnormal eating behaviors.

Shortly thereafter, Barb participated in the standard interview for which she arrived on time and was well groomed and casually dressed. She self-identified as a Caucasian female and was of average height and slightly overweight build. She was cooperative and forthcoming throughout the interview. Her eye contact was good and appeared intense at times. Speech was evenly paced but cautious. Based on her vocabulary and clinical judgment, she appeared to be of average intelligence. Affect was euthymic throughout the interview. Judgment and insight appeared to be good; however, she appeared not to have insight into the fact that she often explained difficult thoughts or emotions through metaphor, potentially as a method of distancing.

After receiving psychoeducation about the process overall followed by well-being in particular, Barb shared her description of feeling "positive" and the fact that maintaining that positive outlook and demeanor was of utmost importance to her. Fairly quickly after presenting this optimistic account of her well-being, she shared insight into her pattern of avoiding negative emotion. The researcher shared that her assessment results corroborated the pattern that she described; however, that she did appear to be experiencing some degrees of negative emotion, despite her efforts to avoid that. Barb acknowledged that she knew that to be true.

Barb had little difficulty sharing her developmental narrative. In so doing, she revealed several insights into her current affective and relational patterns. First, Barb

explained that at age 13, she suffered several seizures and was diagnosed with epilepsy. The diagnosis came as a shock to the family, who became extremely concerned for her. What was worse was that a year later, Barb found that a new medication was ineffective in controlling her seizures and she believed was responsible for irritability and depressed mood, as well. She missed many school days during that year and spent a great deal of time at home, where she became even more irritable and demanding of her parents and other family members. As Barb reported, her attitude changed when she began to compare herself to others in the world who were also suffering with medical conditions. As she continued to gain perspective on her circumstances, she began to feel guilty for her anger, self-pity, depressed mood, and demands. This perspective was effective in pulling her out of that depressive episode. At that point, she also changed medications and her seizures became better controlled.

Since that time, Barb continued to ruminate about how she had conducted herself, particularly her self-pity and her demands. She shared insight into the fact that her guilt over those actions became her motivation to self-sacrifice and to discount her own personal needs. During the interview, it was apparent that although Barb did have insight into that pattern, she was ambivalent about making a change. She acknowledged fears that others would view her as selfish if she disagreed with their opinions or did not honor their requests and also a core aversion to making her own needs known, as others might believe her to be a burden or might not be willing or able to meet her needs.

Her quantitative assessment data and interview results were compiled to create a comprehensive picture of Barb's current functioning. Her feedback session was scheduled for one week after the interview, which gave the researcher time to generate

her report. That report was then shared with Barb, along with an explanation of her strengths, vulnerabilities, and recommendations for increasing her well-being and interpersonal functioning (see full report in Appendix K).

Barb demonstrated a great deal of insight into her functioning, especially with regard to her weaknesses. Therefore, it appeared important to honor that insight by validating and expanding on it, without discrediting the self-knowledge that she had developed. In so doing, she might be more receptive to recommendations and confident in her ability to begin to advocate for herself. Therefore, her report attempted to present an accurate account of her unique patterns, while at times utilizing a tentative tone. The following excerpt is presented to demonstrate that style:

Your relational style appears to be one wherein you maintain a focus on other people and their needs, listen often, and attempt to meet their needs yourself. At the same time, you do not tend to ask others for much yourself. When you feel stressed, you talk to your mother or to your friend; however, you appear to be afraid of feeling weak or vulnerable and so you do not share a great deal of negative emotion with others. Further, you acknowledged a core need for recognition and care from others and yet, at the same time, you might also fear that if you let others see that you have that need, that they might not attempt to meet it, or that they might try to meet that need but disappoint you in some way. The pain that comes with those possibilities might be motivating you to maintain your “happy face” around others rather than show negative in addition to positive emotion.

Potentially, in order to ensure that you do not make yourself too vulnerable or jeopardize the amount of relational value that you have with others, you have likely become a less assertive and more easygoing person. On the one hand, this has been a very adaptive strategy for you and has allowed you to maintain multiple groups of friends as well as close relationships with your family. On the other hand, though, you could potentially be missing out on the possibility of others fully meeting your needs for recognition and being known, understood, and valued for the “real” you, rather than just for the positive or convenient side of you. As such, you might benefit from acknowledging your own core needs and values and attempting to communicate those to others, in your own words and without filtering.

Additionally, the researcher was interested in reinforcing Barb's adaptive strategies. For an individual like Barb, who often felt that others did not value her strength or appreciate her sacrifices, validation was important; however, it was also crucial to point out the maladaptive nature of denying one's own needs and motivating oneself through guilt. While Barb's self-sacrificing pattern and instrumental guilt were addressed in the section above, the following excerpt illustrates validating Barb's adaptive strategies while also reminding her again of the negative emotions she had been suppressing:

In addition, you have clearly shown other adaptive abilities. You maintain your prescribed medical regimen (i.e. medication and visits to the neurologist) in order to control your epilepsy and have been successful for quite some time. You were also able to pull yourself out of a depressive episode by self-motivation, perspective, and reframing your own negative thoughts. There is the potential that, in order to do so, you have been suppressing a level of anger or injustice; however, the adaptive part of that strategy has been your ability to maintain a brighter mood since that time. You indicate strong values, including close family relationships and your catholic religion and both have been important coping mechanisms for you. Finally, you appear to be a strong and motivated student.

Barb appeared to receive the conceptualization and feedback very well. This was evidenced by her statements in the informing session as well as her written feedback about the process. To illustrate, excerpts from her written feedback are included below:

[The report] was very accurate. It was not surprising, but led me to realizations I'd never thought about...I was presented with things I'd never really thought about before and it opened my eyes to a different side of me...I think it was meaningful. It helped me to think about emotions I suppress which I think made me feel better. Very useful.

Barb was presented with several recommendations for improving her well-being and character functioning. During the interview, she had indicated an interest in treatment; therefore, based on that interest, her vulnerabilities, and her endorsements of

mild depressive and anxious symptoms, psychotherapy was strongly suggested. She was also presented with step-by-step considerations for increasing one's emotional awareness, expression, and emotional overregulation. Finally, she was presented with guidelines for understanding and accepting one's core need for relational value. Barb appeared understanding and appreciative of the recommendations as they were discussed.

At the end of the feedback session, Barb was asked to comment on ways in which she might use the information and recommendations that were provided for her. In response, she indicated the following: "I'll use it to improve myself. I don't want to just be average in my emotional health. I want to excel. I want to be as happy and healthy as I can be so I want to take the information + advice and apply it to my life."

Case #3: Chloe

Participant number 1234f (henceforth referred to as 'Chloe') completed the Psychological Check-Up Assessment battery for 1 credit toward her General Psychology 101 research requirement. Upon completion, she was promptly contacted and invited to participate in Part 2 of the study, for 2 additional research credits. In the meantime, Chloe's assessment data were downloaded, scored, and converted to z-scores using the JMU normative data for each of the variables of interest.

According to typical procedure, Chloe's overall level of well-being was considered first. Her well-being was found to be in the average range, relative to her peers ($z = 0.51$). All domains of well-being were in the high range (5 or 6/7) except for health and physical fitness, which she rated 3/7.

Next, the researcher considered Chloe's personality trait profile. Her ratings indicated that, relative to her peers, she endorsed an average level of extraversion, neuroticism, conscientiousness, and openness to experiences. Her score for agreeableness was different across the two measures of personality traits, with one being average and the other suggesting that she might be less agreeable than her peers ($z = -.90$). Chloe's self-concept ratings revealed that she viewed herself to be powerful ($z = 1.69$). Her sense of allowing herself to be vulnerable was average, as compared to her peers ($z = 0.89$).

Her Relational profile revealed an individual that was equal parts dominant and submissive, slightly more hostile than affiliative, and not particularly autonomous or dependent on others. Although a clear profile did not emerge, her results indicated that her sense of being known, understood, and valued was average as compared to her peers and that she was somewhat less likely to experience low relational value. Finally, although her scores indicated that she was receiving appropriate support, she appeared to experience her mother as overprotective ($z = 1.37$).

Chloe's remaining results indicated that she was experiencing less distress than her peers. Her defensive strategies were unremarkable, with the exception of her being less likely to suppress aggression when under stress ($z = -1.17$).

Shortly thereafter, Chloe participated in a psychological check-up interview. She arrived on time for the scheduled interview. She was well groomed and casually dressed. She self-identified as a female who recently emigrated from [REDACTED]. She was of average height and athletic build. She was cooperative throughout the interview, but tended not to volunteer more information than was asked. Her eye contact was intense at times. Speech was evenly paced but cautious. Based on her vocabulary and clinical

judgment, she appeared to be of above-average intelligence. Affect was calm throughout the interview. Judgment and insight appeared to be good.

After receiving psychoeducation about the process overall followed by well-being in particular, Chloe shared her description of feeling at ease and positive as well as driven to be successful in college and in her future career. She shared that she enjoyed college and was currently excelling in her courses. She stated that she enjoyed academic and political debates with others and felt confident in her beliefs. She shared that she had firsthand knowledge of the world's political unrest and felt driven by her experiences. As such, she reported planning to seek a career in International Affairs.

When asked about her background, Chloe shared that she was born and raised in [REDACTED]. She reported a happy childhood and satisfying relationships with her family members; however, she also recounted the ways in which her life was impacted by the country's civil war. Chloe's family suffered a loss of socioeconomic status as a result of theft and repeated vandalism as well as the country's overall economic decline. Nevertheless, Chloe's family appeared to maintain a sense of pride and togetherness.

At age 16, however, Chloe's family sent her away, in hopes of ensuring her safety and a quality education. She was sent to live with her older brother, who had moved to northern Virginia. There, she attended public school and worked to assimilate with the American culture, while maintaining her ties to the culture in which she had been raised. She was glad to have moved, as her primary focus appeared to have been on education and beginning a successful career; however, she reported that she missed her family, especially her mother. Chloe maintained daily contact with her mother as she reported that the separation had been difficult. Her mother was seemingly the only individual with

whom Chloe shared her private thoughts or negative emotion, though the two only occasionally discussed any negativity.

Chloe reported that, privately, she did worry about her family members as well as what might be to come for her war-torn country. When probed by the researcher, though, she appeared not to ruminate on those thoughts. Instead, she reported allowing herself to worry for a short period of time, calling her mother to check out those worries, and choosing to move on and focus her energy on her schoolwork. When asked if she shared her worries with friends on campus, she reported that she was not interested in doing so. She did not appear to be particularly defensive; however, she explained that she did not think that sharing her worries would benefit her or others and certainly would not help the cause.

Following the interview, the researcher compiled all of the information gathered and utilized that in contextualizing Chloe's quantitative assessment data. Overall, Chloe appeared to be a person who had experienced war, adversity, trauma, and separation from her family; however, whereas others might be emotionally distraught, she seemed to be thriving in her current environment. She reported worry and lowered mood at times, but not for prolonged periods and not to the point of functional impairment. She seemed to have used the anger and adversity that she had experienced to fuel a sense of purpose and drive toward being an agent of change herself. She was resolute in her intentions to become an international human rights lawyer and to represent those who had been victims of terrorist activity and human rights violations.

Thus, it appeared that Chloe was remarkably well adjusted, given her experiences. That being said, she was also an individual who was alone in her circumstances and not

in the habit of sharing much of her internal world with anyone except her mother. It was recognized that there was a cultural component to Chloe's desire to keep her distress at bay as well as to voice that distress only within her family of origin. Despite that, part of her desire not to share with others seemed also to have come from her experiences.

During the interview, she had shared that on numerous occasions others had betrayed her father's and sister's trust by spreading rumors to other parties. This had further reinforced Chloe's sense that it was best not to share sensitive information. With everything taken into consideration, the researcher was interested in reinforcing Chloe's adaptive strategies while also helping to educate Chloe on the fact that hyperautonomy could represent vulnerability to loneliness and insufficient support, which could be detrimental in the event that she experienced further distress in the future. As such, the following description was created and presented in her psychological check-up report (see Appendix L for full report):

You reported that you feel comfortable talking with friends, but that you tend not to share the content of your worried thoughts. This hesitation to share could be related to your statement that you feel uncomfortable sharing some of your private thoughts, for fear that people might spread that information to others. Indeed, you indicate witnessing others being mistreated in this way. Because of this, you tend to share your worries with your mother but less often with your friends.

You indicated that when you experience a great deal of worry, you tend to hide it from others, with the exception of your mother. While you appear to share most things with others, you might not feel comfortable relying on others to help meet your own needs. This could potentially be influenced by feelings of mistrust or simply by uncertainty about how to ask for what you might need. Although this has not been an area of significant concern for you, it could be a potential risk factor for becoming overwhelmed or disconnected in the future.

The primary intervention and recommendation for Chloe consisted of increasing her emotional sharing and support from others. With that said, the researcher was interested in highlighting and reinforcing Chloe's innumerable strengths and adaptive strategies. To illustrate, the following excerpt from her psychological check-up report is presented:

You were the first of your friends to leave the country, though you reported that they have all since moved away. You reported coping with the transition by maintaining daily contact with your mother and shared that you were well received by your new peers. In fact, you reported that you "made best friends right away." You indicated that you were able to assimilate into the culture of the United States while maintaining the cultural ideals with which you have been raised.

You have evidenced great strength in your ability to tolerate distress, become independent, and adapt to a new culture. You have identified a career path and feel passionate and motivated to help others. You also appear to relate to others and to make friends with ease and to be comfortable sharing most things with them as well as to support them yourself.

Chloe's report largely recounted and organized her adaptive narrative; however, it seemed important to again remind her that, while her adaptations were impressive, emotional growth and understanding were possible. As Chloe did acknowledge wanting to continue to increase her overall level of well-being, the recommendation to increase her emotional sharing and learn to rely on her support network was presented in such a way. To illustrate, the following excerpt is included:

What you might want to consider is whether you feel you have enough support around you as well as an outlet to discuss your concerns. You indicate that you feel mistrustful of others when it comes to sharing very private details; however, you might consider whether there are individuals around you that you might trust enough to share your potential worries, fears, sadness, and concerns. It is realistic to believe that if you have sufficient support around you and feel that others know you, understand you, and value you (e.g. meet your need for relational value), your well-being might further improve.

During the majority of the feedback session, Chloe appeared receptive to the assessment results in general. When the conversation turned to the issue of opening herself up emotionally, Chloe appeared to pull back and justified herself by stating that her parents and sisters were proud of the fact that they did not tend to share their distress with others outside of the family. As such, the researcher validated Chloe's experience and proceeded tentatively. In service of that goal, the researcher repeated some of Chloe's own personal descriptions, including her occasional isolating behavior after watching the international news coverage on television and her repeatedly informing friends that she was "fine" at those times. After a few minutes, Chloe nodded and seemed to feel more at ease.

The researcher then asked if Chloe would like to transition to the recommendation section, to which she indicated that she was interested. The researcher explained the recommendations, which consisted of psychoeducation on emotions and emotional expression, including potential overregulation. Chloe followed along and nodded as she received the information. She went on to state that the descriptions made sense and that she could see how they could be beneficial to her. Further, while she stated that she was not interested in psychotherapy, she did indicate that she would like to increase her emotional sharing with others. As she described, she did not believe that she was experiencing problems at that moment, but was very receptive to the notion that she could begin to utilize her support network now in service of ensuring that she would have support in the future, should she require it.

Chloe's written feedback indicated that she was receptive to the information that was presented to her but her paucity of detail potentially corroborated the researcher's

sense that she was underwhelmed. For example, in response to the question of whether the information contained in the report added to her sense of knowledge about herself, she responded: “I feel like I knew some of the information it described about me but there was some information that was interesting to hear about.” That being said, Chloe’s overall feedback did indicate a positive response. The following excerpts are presented in support of that notion: “It was meaningful and I believe it was useful to look at and read through,” and “The information made me think about my personality and who I am as a person.”

Case # 4: ‘Diane’

Participant number 3474 (henceforth referred to as ‘Diane’) completed the Psychological Check-Up Assessment battery for 1 credit toward her General Psychology 101 research requirement. Upon completion, she was promptly contacted and invited to participate in Part 2 of the study, for 2 additional research credits. In the meantime, Diane’s assessment data were downloaded, scored, and converted to z-scores using the JMU normative data for each of the variables of interest.

Diane was assigned to the clinical researcher GH for the psychological checkup. According to typical procedure, Diane’s overall level of well-being was considered first. Her well-being was found to be in the “Mixed to Somewhat High range” (Total score = 47), which was just below the JMU mean ($z = -0.62$). She demonstrated a somewhat variable profile on the H10WB, with high scores on Personal Growth (7), Health and Fitness (6), Academic Functioning (6), and Relationships with Others (6). However she

was low or mixed in Mastery/Coping (2), Autonomy (3), Purpose in Life (3), and Emotional Health (4).

Next the researcher examined her emotional/experiential profile. Her PANAS score was indicative of someone who was emotional and experienced both positive ($z = .91$) and negative emotions ($z = 2.10$) more frequently than most. Her PHQ-9 score, which assesses for the presence of depressed mood was in the normal range ($z = .2$), but her scores on the GAD-7 were highly elevated ($z = 2.2$), indicative of clinically significant levels of anxiety. Consistent with this profile, her trait neuroticism scale on the Newcastle was somewhat elevated ($z = .64$) and her Emotional Stability score was very low on the TIPI ($z = -2.59$). There was also some suggestion that she tended to over-regulate some aspects of her feelings (WAI Suppression of Aggression $z = 1.1$; WAI Repressive Defensiveness $z = .8$).

In terms of her relational structure and interpersonal style, consistent with her high score on the H10 relationship item, she had a positive high relational value score ($z = 1.34$) and a lower than average low relational value score ($z = -.84$). In terms of her interpersonal style, she scored high on the Newcastle agreeableness subscale ($z = 1.21$) and was clearly in the “other oriented” quadrant on the Influence Matrix process scales (Power $z = -1.5$; Freedom $z = -3.4$ and Love $z = 2.5$). Thus the picture painted Diane as an interpersonally attuned, empathetic, sensitive individual who felt strong needs for connection, approval and being like and might at times have difficulty asserting herself or separating herself from the judgments and opinions of others.

Data regarding Diane’s conscious self-concept were consistent with the data about her emotions and interpersonal style. She scored above average on the SCS Likability

subscale and Morality subscale. At the same time, she was higher than average on her Vulnerability subscale ($z = 1.36$) and lower on her sense of Power ($z = -1.2$) and much lower in her sense of Giftedness ($z = -2.17$). Finally, there were no significant indications of any problems with sleep, eating, or substance use.

The interview portion was later completed. She arrived on time for the scheduled interview and appeared as a well-groomed, casually dressed Caucasian female. She was of average height and athletic build. She was cooperative and friendly throughout the interview, but also presented as a bit cautious and sensitive. At times she became tense and tearful, when discussing her history of problems with anxiety.

After receiving information about the overall process, including clarification about the nature of the study, the nature of the questionnaires that she had filled out, and the interview and informing process, the interview began with the usual prompt asking Diane about her life and how things were going overall. Diane began by talking about things that were going well in her life, namely her sense of friendships and belonging that she had at JMU. She also reported that she had a good relationship with her family of origin and especially her mother who had always been one of her closest confidants and she considered her “best friend.” Diane then reported that she had recently experienced some disappointment regarding her hopes for attending graduate school—she had been rejected at each place that she had applied and this had resulted in her feeling stuck in her next step in life.

This opened up a discussion of her desire to be a physical therapist, which actually was something she just always “figured she would do,” but also verbalized that, upon reflection, she had in many ways “been going through the motions” when it came to

her academic functioning and future career. She reported that although she was fine with the idea of being a physical therapist, she was not passionate about it, nor was she very clear on why that was the career for her. Indeed, this conversation opened up some discussion about Diane not really spending much time reflecting on who she was and why, nor about the person that she really wanted to be in her life.

The interview then shifted into her emotions and it was very clear that she had been intermittently struggling with anxiety since high school. These problems had recently taken a turn for the worse, as she had been having “anxiety attacks” about once per week over the past few months. These would emerge when she was stressed about something she had to do or perform, such as a presentation in class, and she noticed that they had worsened since she learned she was not going to graduate school. She also described herself as a typical worrier, often anticipating problems, worrying about what others thought of her, worrying about if she would do something wrong or get criticized. She would worry about performance issues, social issues and general problems. She acknowledged that she is sometimes kind and helpful and submissive in relations to others because she had deep concerns and fears about conflict. She also reported that she had core concerns about needing others’ approval and that she did not have a strong, independent conception of herself. She stated that she had gone to the Counseling Center at the beginning of the year and was placed in a treatment group called “You’ve Got This,” but this was reportedly unhelpful.

Additional exploration of Diane’s history revealed some originating events that likely played a role in the emergence of her anxiety. First, she reported that although generally she had a very happy childhood and supportive parents, there was a time, just

before her adolescence, when her parents went through a very difficult period. Indeed, her mother moved out of the house for a couple of months and although she stayed engaged, the family was clearly disrupted and distressed. However, her mother then moved back in and the family seemed to return to equilibrium, although she was not sure if her parents' relationship returned to the same degree of closeness. What was notable (and it dawned on Diane as she discussed it) was that she never knew or asked about the details of what happened and never talked with her mother or father about their relationship.

Another, likely even more formative, event was a quite traumatic series of encounters she had with a strange "friend" at high school. She reported that a rather odd girl attached herself to Diane and during particular episodes, would become threatening and belligerent. Diane reported that at one time she was choked by this individual who then informed her that if she ever told anyone then she would hurt either Diane or her family. For months during her senior year of high school, Diane experienced a fairly intense period of fear from this relationship. In fact, she reported continuing to have emotional reactions to seeing notes from the woman on Facebook. She was afraid to "defriend" her because she continued to worry that, if provoked, this friend would injure Diane or her family. Moreover, Diane had never shared this event with anyone in any depth and was tearful and afraid as she processed it in the interview.

At the end of the interview, Diane was provided a brief summary of what to expect in the informing, as well as some information about how she might feel after leaving the interview, given that she had opened up about several elements that were

emotional and had not been fully discussed with others. She said that although she felt fatigued, she appreciated the chance to share and felt good about the interview.

One week later, Diane met with GH for the informing and the write up (in Appendix M) was shared with her. The picture presented to Diane was that she was in the “Mixed to Somewhat High Range” of well-being, with strengths in the area of relationships, physical health and fitness, and academic functioning, but difficulties in the area of emotional functioning, coping and an autonomous, reflective self-concept. The first domain reported on in the major findings section pertained to her emotional functioning, where it was shared that:

You’ve been experiencing significantly high levels of anxiety, which are difficult to control and predict. You shared that over the past year you have been dealing with notably upsetting episodes of anxiety. Although these were not necessarily full-blown panic attacks, they have been very distressing and difficult to control and predict. The results from both the quantitative measures and the interview are suggestive of clinically significant levels of anxiety (i.e., would likely warrant an official diagnosis). The domains include experiencing unpredictable anxious reactions (e.g., in school), generalized feelings of tension and worry, and social anxiety in the form of anticipating what other might think of you or how you might be judged.

In the informing, she was told that she clearly had “clinically significant” levels of anxiety and probably met criteria of a Generalized Anxiety Disorder.

Her good relations were then explored and her strengths of being empathetic, sensitive, caring and fun were highlighted. Some about difficulties she might have expressing her own needs and being assertive were discussed as well as how she tends to suppress anger and avoid conflict. Further, we discussed the pros and cons of this way of being in relationships.

The conversation then shifted to the development of her problems with anxiety and several elements that likely intersected to contribute were tied together. First, that she likely had a somewhat anxious temperament, meaning that she was sensitive to negative feelings to begin with. Second, we talked about how the fact that the disruption in her family was never discussed might have resulted in a sense of uncertainty and vulnerability in relationships. Third, we talked most about the trauma that she experienced in high school in relationship to the threats from her “friend.” We also discussed both how she had never been coached in how to deal with negative feelings and how she had not developed a strong, autonomous, powerful sense of self. With that lens we returned to her career trajectory and tried to reframe the disappointment regarding not getting into a physical therapy program as an opportunity for her to really begin to reflect on who she was and what she really wanted to do.

Diane was provided three recommendations. First, she was provided two self-help references, one on negative emotions from an acceptance and positive psychology framework and the other on anxiety from an evidence-based mindfulness approach. Second, she was recommended to foster the process of self-exploration and career by taking advantage of career counseling here at JMU. Finally, she was provided with a summary of what psychotherapy might entail, and specifically given a frame for what kind of psychotherapy would likely be helpful, namely one that enabled her to feel safe and heard and competently understood, one that allowed her to explore some of the origins of her anxiety and integrate that into her narrative of self, and one that allowed her to gain exposure to some of her negative and split off fears and to develop more adaptive ways of coping than avoidance based strategies.

At the end of the informing session, Diane provided written feedback about her experiences as a participant in the psychological check-up study. Her feedback responses indicated that Diane viewed the information contained in her report to be accurate and believed that it added to her sense of self-knowledge:

The report was very accurate. Nothing was a surprise to me, but it made me more aware of my well-being...the information definitely helped me become more aware of my areas of well-being that are positive and negative.

From Diane's responses, it was also evident that she felt motivated to utilize the recommendations provided and to seek greater self-knowledge: "I am going to look for someone who can help train me on my anxiety and help me gain a better self-concept. I will also look into the books that were suggested."

Participant Case Studies: Conclusion

The above case study descriptions were provided in service of illustrating the psychological check-up protocol as it was implemented. The descriptions were also shared to facilitate a de-briefing about the protocol and, more specifically, discussion of the feasibility and utility of the psychological check-up. As stated above, feasibility was examined along the following areas: a) development of a "psychological check-up" protocol, grounded in Henriques' conceptual models of character and well-being; and b) implementation of that assessment protocol design in at least 15 university students. Utility of the psychological check-up protocol was also examined across multiple pre-determined areas: a) assessment of each distinct component's clinical utility, which includes assessment interpretation, in vivo interview, and feedback session; b) overall accuracy of the conceptual feedback report, as evidenced by participant response; and c)

level of utility and meaning garnered as a result of the psychological check-up experience, as evidenced by participant and informed by clinical and professional judgment. A discussion in each of the aforementioned areas is provided below.

Feasibility: Creating and Implementing the Psychological Check-Up

Feasibility: Development of a Psychological Check-Up Protocol

As discussed in Chapter 3, a new protocol was successfully developed, grounded in Henriques' integrative conceptual theories for assessing and understanding people. The Psychological Check-Up protocol was designed to offer a comprehensive map of human functioning, taking into consideration individuals' current levels of well-being as well as their overall character structure. In order to assess well-being and character structure, this project also made use of a unique measure for assessing well-being across functional areas of living and a new conceptual map of character functioning that integrates major psychotherapeutic paradigms, including behavioral, cognitive, and psychodynamic theories.

Feasibility: Implementation of the Psychological Check-Up Protocol

The Psychological Check-Up was successfully implemented in a sample of university students. From its inception, the Psychological Check-Up was intended to be brief and therefore ideal for efficient, widespread use. In service of that goal, an online version of the entire assessment battery was made available to participants. The online battery was created using the Qualtrics web development platform and every step was taken to ensure security and HIPAA compliance. Upon completion, each participant's

responses were promptly downloaded and translated into an SPSS data set where raw scores were converted to z-scores, using means and standard deviations collected from the standardization sample. All participants who completed the online battery in part 2 of the study were labeled according to their 4-digit self-generated code, which was then matched to the participant name indicated on the informed consent for the purpose of follow-up email contact. All participants were sent up to three email invitations to make an appointment with a researcher for a thirty minute to one-hour interview. Those who completed the interview were scheduled to come back in approximately one week later for a feedback session where they also received their written assessment report.

The interview session involved the following: a) psychoeducation about the assessment process, b) sharing an overall snapshot of the participant's levels of well-being in specific domains c) conducting the semi-structured interview (see Appendix G), d) answering any participant questions, and e) scheduling the feedback session. This process was feasible in each of the cases (n=19). The time frame was approximately 60 minutes, although it varied depending on the amount of material and difficulties the participant reported.

The feedback session generally took place approximately one week following the interview and was structured as follows: The clinical researcher outlined the agenda for the meeting and provided participants with a copy of their psychological check-up report. The researcher then presented the major findings, which typically consisted of participants' levels of well-being overall as well as in specific areas, followed by one or two additional findings, as were appropriate to that particular case. For instances, major findings might have consisted of a participant's counter-dependent relational style and

experience of low relational value. The researcher paused after every major finding to check for understanding and validate participants' reactions. The "Brief Historical Narrative of Key Events" was presented in the same way. Finally, participant and researcher discussed the recommendations. Recommendations consisted of a) psychotherapy (which was presented as an opportunity to all participants) including contact information for the university counseling center and university outpatient clinic, b) appropriate bibliotherapy resources, and c) step-by-step guidelines for understanding emotions, emotion regulation techniques, and recognizing the human need for relational value. Participants were encouraged to ask questions and discuss their reactions all throughout the feedback session and the researchers offered clarification and additional examples as needed.

In most cases, the feedback sessions required the projected 30 minutes; however, certain feedback sessions lasted approximately 45 minutes. Thus, it appears that researcher flexibility in the time allotted for interview and feedback sessions was a crucial component to successful implementation.

As noted in the Method section describing Study 2 participants, the researchers did find that completing the full psychological checkup was slightly more difficult than expected. Although 65 possible participants were contacted, only 22 responded with interest and 19 completed the interview. All of the 19 participants who engaged in the interview went on to complete the informing session and provide feedback about the experiences with the psychological check-up process. Of the participants who were contacted via email for follow-up feedback, only 50% responded by sending back a completed form. Thus, it became clear that there was substantial drop off from the

number of participants who completed the online assessment battery and provided a name for contact purposes (n=65) to the number of individuals who actually completed the interview and feedback session phases (n=19) as well as to the number who sent back the follow-up feedback form (n=9). Despite the lower than projected number of participants who were interested in completing the entire study, the researchers were able to successfully implement all aspects of the protocol with those who were interested.

Clinical Utility of the Psychological Check-Up

Clinical Utility: Reflective Assessment of Each Component's Utility

As this project represented a new protocol development design, it is both useful and necessary to critically examine the clinical utility of each component. Specifically, Part 2 of the psychological check-up consisted of a computer administered assessment battery, scoring and interpretation of those completed assessment measures, in vivo assessment interview, report generation, and an in vivo feedback session with each participant. In this section, the utility of each component will be explored using clinical judgment and relevant examples collected during this pilot project.

First, the psychological check-up assessment battery was compiled to assess participant functioning in a way that was organized by and corresponded to Henriques' models of character and well-being. As such, established measures of functioning were selected in accordance with the various domains identified by Character Adaptation Systems Theory, the Character Wheel and the Nested Model of Well-Being. Collecting the quantitative assessment data from each participant provided a profile that depicted participant functioning in their current environments and their adaptive tendencies,

dispositions, identity structure and, if appropriate, areas of psychopathology. In this way, the assessment battery helped to capture one of the key features of the psychological check-up: its breadth. This can be seen in the fact that participants answered wide-ranging questions related to their emotional health as well as their sleep, alcohol use, relationships with parents, and self-concept.

The assessment battery was expected to be most clinically useful if administered before the in vivo interview. The reason for this was that the data could be used to create a preliminary conceptualization of each participant and therefore inform the direction and types of questions that might be emphasized. Indeed, that plan was judged to be clinically useful. When it came time for researchers to meet each participant and conduct the interview itself, they found that they had preexisting knowledge of the person who was sitting across from them. In this way, the interview could be targeted to certain domains of functioning within which the researcher knew the participant was particular thriving or struggling. The research team, which consisted of two advanced doctoral psychology students and one licensed clinical psychologist, found success in a tentative approach to interpreting the assessment results and remaining open to information that might confirm or disconfirm their preexisting notions. Indeed, in most cases, participants shared their overall narrative in a way that made sense to them and that corresponded well with the researchers' interpretations of the quantitative profile. Upon reflection, the only drawback to interpreting the data before the interview might be the researchers' tendency to want to explore important areas, such as problematic substance use or a high score for interpersonal hostility, despite a participant's desire to avoid those domains;

however. As such, we found that proceeding tentatively and remaining open were important and successful strategies.

The interview process represented the crux of the psychological check-up procedure and was found to demonstrate great clinical utility. While the researchers had existing knowledge of each participant's functioning along various domains, that information was interpreted with caution and referenced against the participants' qualitative narratives. Upon meeting with participants, the majority presented an overall narrative that confirmed their preexisting quantitative results; however, the narrative and behavioral observations pulled the various pieces of information together, contextualized them, and provided a unique history. Further, participants' descriptions provided rich language that was utilized in the report and feedback phases. For instance, one participant used the phrase, "I wish people would just care more" to describe her experience of low relational value. That phrase was included in her psychological check-up report and, upon hearing her own description, she became emotional and seemed to ultimately recognize the importance of that need. Finally, the interview phase allowed for a meaningful, albeit brief, relationship to develop between the participant and clinical researcher. Each researcher spent time explaining the process, asking questions, normalizing, validating participant experiences, and building rapport. Taken together, the interview phase was truly the crux of the process itself and arguably represented the most significant feature of the psychological check-up.

The feedback phase proved to be successful, as well. It was found that participants responded well to the structure of the feedback session. The structure consisted of revealing the major findings as well as an overall conceptual narrative,

which was guided by a reading of the actual report in session. However, after every section, the researcher paused, checked for understanding, and offered additional descriptions or examples, as needed; the researchers also offered the same for any material that was especially challenging.

The psychological check-up report itself described participants' functioning in terms of major findings, a developmental narrative, and, where appropriate, recommendations for adaptive living going forward. The write-up ranged from two to five pages, depending on the extent and nature of the findings. The major findings generally reported on the following: 1) overall description of the individual's psychological health and well-being; and the more specific domains of 2) habits and lifestyles; 3) emotions and emotional functioning; 4) sense of relational value and interpersonal style; and 5) identity and coping.

The clinical researchers reported that the 19 feedback sessions were successful overall. It was found that participants received the feedback well and without incident. No participants disclosed that they were offended, put off, or unappreciative of the feedback that they received. The only less positive reaction was from a participant that felt underwhelmed by the feedback; however, that individual was functioning well across various domains and so predominantly received positive feedback for his adaptive strategies. No participants became visibly overwhelmed by the feedback process. The individuals who were confused or had lower insight were offered a great deal of psychoeducation, validation, and normalizing. In those cases, feedback sessions were extended to accommodate participant needs. Finally, participants also appeared to receive their recommendations well. No participants seemed dissuaded by the recommendation

for psychotherapy, which was presented to all individuals. Many participants remarked that they would like to obtain the recommended bibliotherapy resources. In particular, the written step-by-step recommendations for increasing emotional awareness and improving relational value appeared to be the most appreciated method of recommendation. Many participants stated that the included descriptions felt beneficial.

Overall, each component of the psychological check-up worked largely as hoped. The assessment battery provided a snapshot of participant functioning across a wide variety of functional areas. Scoring and interpretation were useful and efficiently structured, to reduce the level of demand on researchers as well as the potential for human error. The interview phase afforded a medium for contextualizing and making sense of the data while also creating a space in which the researcher could form a relationship with the participant and access their experience. Finally, the feedback phase proved its clinical utility by offering participants the overall results of their psychological check-up as well as recommendations in a therapeutic atmosphere that was conducive to growth and learning.

Clinical Utility: Overall Accuracy of the Conceptual Feedback Report

In order to evaluate the accuracy of the psychological check-up, a participant feedback questionnaire was developed. The feedback questionnaire contained 5 questions and was administered to participants at the end of their informing sessions. As part of that questionnaire, participants were asked to comment on their report's accuracy: "Do you feel as though your report described you accurately or did it seem to fit for you?"

In response to the above question, it appeared that all 19 psychological check-up participants indicated that the information contained in their reports was accurate. The following excerpts are presented as a sampling of that feedback below:

“Yes, the report did a good job describing me and was a good fit.”

“Yes I do feel that my report was very accurate and true of my life experiences.”

In addition, many participants also expressed that the information added to their self-knowledge. For example:

“Yes, I feel like everything was spot on, especially stuff that I wasn’t aware of, but this report put how I was feeling into words.”

“The report seemed to fit for me and I learned some things that I didn’t already know.”

“Yes. It described me very well. I realized reading it true things about myself that I hadn’t really realized before. I think it fit for me.”

After completing the assessment and informing session, one participant indicated that greater psychoeducation allowed him to better understand and contextualize the information that they received:

“...I felt after understanding the dimensions [of] psychological health the report was accurate.”

The participant feedback shared above points to the importance of psychoeducation as part of the informing session. While it was found that some participants had insight into their internal processes, many did not. More commonly, participants appeared to have partial insight into their maladaptive patterns, such that they might report a particular vulnerability acquired in childhood due to neglect or

invalidation but not be aware of the implications that they have experienced in adulthood. As such, the psychoeducation component of the informing session was crucial to the overall process and allowed participants to better understand, assimilate, and own their conceptualization and recommendations.

As can be deduced from the feedback received, it was determined that all 19 participants found the psychological check-up report to authentically capture their experience. The feedback and resultant qualitative analysis thus supports the notion that the psychological check-up can produce an assessment report that participants judge to be accurate and a good fit for them.

Clinical Utility: Participant Feedback about Overall Utility and Meaning

To determine the psychological check-up's overall level of utility and meaning, the researchers analyzed all written feedback provided by the participants after completion. In particular, two feedback questions were developed for those purposes. Of those, the first question was: "Was the information that you were given meaningful to you? Did you find it useful?" All 19 participants indicated that the information was meaningful and useful. Many participants even shared reasons to support the psychological check-up's utility. The following responses are presented as a sampling of that feedback:

"Yes- very much so. It acknowledged the areas I know I struggle with but refuse to act on thus far."

"Absolutely. The information was very meaningful and useful because it addressed (what I thought to be) the most important characteristics of myself. It was more than helpful."

“Yes, I’m excited to challenge my self critic the next time I have a negative thought.”

“Yes the information helped me make sense of a complex system in relation to how it is projected through different aspects of my life.”

“It was nice to hear it from someone else instead of just guessing what I think I need to do. I can now use what I got today to better myself.”

The second question associated with utility and meaning was designed to assess how participants might incorporate this feedback into their lives. The goal of the question was twofold: to provide feedback for the researchers regarding utility while also prompting participants to consider really taking action to implement the feedback. The question asked, “In what ways do you think you might use the information that you were provided about yourself?”

In response, 14 participants indicated that they plan to use the information to foster personal growth and self-knowledge. For example:

“I’ll use it to improve myself. I don’t want to just be average in my emotional health. I want to excel. I want to be as happy and healthy as I can be so I want to take the information + advice and apply it to my life.”

“I will start to ask myself deeper questions and reflect on myself to try and get a better sense of who I want to be and what I want to do.”

Four participants indicated that they were interested in seeking help in the form of counseling or psychotherapy. For instance:

“I hope to speak to a counselor + will be more in tune with what my body/emotions are meaning to tell me.”

One participant's response embodied an interest in greater learning, self-knowledge, and appropriate help seeking. That response is shared below to illustrate the type of growth promotion that the psychological check-up was designed to foster:

"I think by recognizing the areas in which I need help I will be able to figure out the best suitable solutions for myself and move forward with helping myself internally, as well as seeking help from other sources. This experience has made it easier for me to talk to others and more open to the idea of therapy, so I will definitely be willing to look into that!"

Taken together, the feedback from participants was overwhelmingly positive. In particular, participants indicated that the information garnered as part of the process was both useful and meaningful. Additionally, all participants stated that they plan to use the information in an adaptive way. Of those participants, 4 individuals disclosed a newfound interest in engaging in therapy to continue the growth and exploration process. Thus, the psychological check-up was found to demonstrate both utility and meaning, as per qualitative participant report.

Chapter Six

Discussion

The goal of the current project was to develop a comprehensive and systematic way to effectively assess character functioning and well-being in college students. The proposed assessment and formulation protocol might serve as a new and valuable health care tool, as well as a guide for adaptive living. In the past, other approaches have been developed based either on specific psychotherapeutic paradigms (e.g. cognitive psychotherapy) or via purely empirical and statistical analyses (e.g. Big Five, MMPI-2). The current project, however, was designed to integrate those developments into a more comprehensive and efficient protocol. Further, the current project was informed by a new conceptually clear and integrated “Nested Model” of well-being (NM; Henriques et al., 2004) and an integrative view of character functioning as conceptualized according to Henriques’ Character Adaptation Systems Theory (CAST) model. The assessment protocol was implemented and evaluated here within a sample of college students, in an attempt to address the rise in pathology and difficulty in effectively meeting the demand for mental health services within that population.

Specifically, the current project was designed with awareness of the college student mental health crisis (CSMHC) in mind. There is research to suggest that young adults (and college students in particular) endorse depression and anxiety in increasingly large numbers (ACHA, 2009). College students have ranked depression and anxiety among the top overall health concerns and have indicated that such symptoms have negatively impacted their academic performance. A few potentially complementary explanations have been offered. Developmentally, emerging adults are tasked with

managing increased freedom and room for existential exploration. Though many emerging adults might have been placed on a fast track to academic achievement, many discover that, perhaps due to parental over involvement, they do not have the necessary resilience, self-awareness, or social skills to navigate the tasks inherent in this stage. In this way, a culture of high achievement, low emotional maturity, and underdeveloped problem solving skills is believed to have developed and contributed to today's students' low distress tolerance. Further, as treatment, aid, and advocacy efforts have improved, there are now students on campus who might not have attended college in the past; thus, there has been an inherent increase in college students with severe mental illnesses, negative affect, and cognitive and physical impairments. Taken together, these issues have precipitated a crisis of need, yet help seeking has not increased with that rise in distress and identity exploration.

The psychological check-up is poised to address the college student mental health crisis because it represents a method of identifying and treating at-risk individuals in a way that is efficient, systematic and also theoretically grounded. It appears that college students in particular might not have a strong sense of how they are functioning; perhaps more importantly, they also do not seem to know why. The psychological check-up offers a snapshot of their well-being functioning, including their current levels of distress and pathology. Moreover, the process focuses on their narrative and identity, specific trait and relational profiles, defenses, and common daily living patterns. Participants are encouraged to make sense of their histories in a way that potentially fosters self-knowledge and adaptation. New insights are couched within a supportive frame and each participant is provided with further resources to manage and facilitate change. Based on

their experiences with implementing the psychological check-up in a sample of college students as well as those participants' positive feedback responses, it is the clinical researchers' belief that the psychological check-up is an effective method of assessing and addressing the CSMHC. Specifically, the protocol successfully demonstrated both feasibility and utility. In support of that notion, experiences with each phase of the psychological check-up pilot project will be discussed below.

Discussion of Psychological Check-Up Study 1

Phase 1 of the current study consisted of large-scale data collection in service of developing normative scores for JMU students. For this, the psychological check-up battery was placed entirely online via a secure Internet survey service, Qualtrics. By placing the battery online, we were able to reach a large number of participants within a brief time frame and without the additional labor that would be required if a clinical researcher were to be physically present during the assessment phase for each individual participant. Data were then downloaded to SPSS to be scored. In addition to time saved, we believe that automatizing the scoring process in this way also reduced the potential for human error.

Current Trends in JMU Student Profiles

Upon completion of phase 1, participant data were scored and examined in aggregate. Examination of those normative scores revealed several overall trends among JMU students. First, overall well-being in our sample was in the "somewhat high" to "high" range, at least based on self-report. This finding was consistent with results of the

Healthy Minds survey data collected from JMU students in the past (Eisenberg et al., 2013), which revealed that JMU students scored significantly higher on a measure of “flourishing” than their peers of other universities. Ratings across specific life domains ranged from the “moderate” to “above average” range, with the highest being “relationships with others” and the lowest being “academic functioning.”

JMU students’ scores for mental health screening measures showed an overall mild level of depression and similarly mild level of anxiety. That being said, there are still many JMU students who present with significant levels of depressive and anxious symptoms. Specifically, closer analysis revealed that 20% of participants endorsed at least moderate depression and 3% of participants endorsed severe depression. At the same time, 19% endorsed at least mild anxiety and 5% endorsed a moderate level of anxiety. Further, in our sample, just over half (51.6%) endorsed a problematic level of drinking according to recommended cut-offs. Other substance use was much less prevalent, but 8% endorsed moderate use and 5% substantial use of substances. This was consistent with JMU student data collected by Eisenberg and colleagues (2013), which revealed that, compared to other college students, JMU students tended to endorse lower levels of depression and anxiety, though alcohol use (particularly binge drinking) appeared to be greater than that of students from other institutions.

As compared to Eisenberg and colleagues’ (2013) findings, it appeared that our sample had a lower proportion of positive depression screens (8% compared to 12%); however, our sample had a substantially higher rate of anxiety (22.4% compared to 14%). That being said, it should be noted that Eisenberg and colleagues administered a different anxiety screening measure than was administered in this study. Interestingly, in their

2013 sample, 8.9% endorsed ever being diagnosed with ADHD. Although we did not assess history of ADHD diagnosis, a screening for current ADHD symptoms did reveal that 8.9% of our sample appeared to screen positive for ADHD. Of course, in all cases, results should be interpreted with caution, as they are solely based on brief symptom screening measures typically meant for a primary care setting.

With regard to psychological adjustment, our sample appeared to experience an average level of distress (Weinberger, 1998) and dysfunctional attitudes (Beevers et al., 2007) as compared to other young adult samples. When compared to an earlier normative sample, JMU students also endorsed an average level of both positive and negative affect (Watson et al., 1988). However, our sample appeared to feel more confident in their coping self-efficacy as compared to a previous student sample (Chesney et al., 2006).

With regard to trait functioning, our sample seemed to score in the medium-high range for 3 of the “Big 5” personality traits: conscientiousness, openness, and agreeableness. Interestingly, research has shown that high endorsement of those 3 traits is positively associated with academic achievement (Lounsbury et al., 2003 and Farsides & Woodfield, 2003 in Komarraju, Karau, & Schmeck, 2009), even though our participants rated academic achievement as their area of lowest well-being functioning. That being said, results of the personality inventories used in this study were interpreted with caution due to reliability concerns (discussed in greater detail in a later subsection).

Examination of interpersonal dimensions, as mapped by the Influence Matrix, revealed that participants on average experienced greater High Relational Value than Low Relational Value. With regard to typical strategies utilized, on the Love dimension, participants tended to be much more affiliative than hostile. On the Power dimension,

they endorsed more dominant than submissive strategies. When it came to the Freedom dimension, which consists of autonomy versus dependency, they endorsed almost an equal level of each, placing them between those two poles (e.g. an equal level of autonomous and dependent strategies). In general, the combination of strategies endorsed is thought to be most strongly related to the experience of high relational value, wherein individuals feel known and valued by important others and are thought to have the best chance of having their relational needs met.

Discussion of Psychological Check-Up Study 2

The Psychological Check-Up protocol was designed to offer a comprehensive map of human functioning, taking into consideration individuals' current levels of well-being as well as their overall character structure. The project made use of Henriques' measure for assessing well-being (grounded in the Nested Model) across functional areas of living and a new conceptual theory of character functioning (CAST) that integrates major psychotherapeutic paradigms. The protocol was implemented in a sample of college students, who completed an online assessment battery, individual interviews, and feedback sessions, which included written reports of their current functioning, unique conceptual profiles, and recommendations for greater adaptive living.

Prior to implementation, it was stated that the psychological check-up would be deemed successful if the protocol demonstrated feasibility and utility; as such, evidence for achieving each criterion will be discussed. The protocol was believed to demonstrate a high degree of feasibility. First, the assessment protocol was successfully created. Second, the underlying structure was specifically grounded in the proposed conceptual

models of well-being and character functioning. Third, the researchers were able to identify established measures associated with the domains of those conceptual models, including: well-being, habits (sleep, substance use, and eating), experiential self (affect), defenses (psychological adjustment and coping self-efficacy), relational health and quality (relational strategies/motivations, attachment, and parental bonding), justifications (dysfunctional attitudes), personality traits, identity (self-concept), values and virtues, and pathologies (ADHD, depression, anxiety, and problematic personality patterns). Fourth, the researchers were able to create a procedure for interpreting the scored assessment data in the context of a standardized functional student profile. Fifth, a structure was identified for the protocol, from online administration to scoring, interview, comprehensive interpretation, translation to written form, and individualized feedback. Therefore, the feasibility criterion was achieved.

Next, the psychological check-up protocol was judged to be a highly useful and meaningful process, with each of the specific components of the procedure contributing unique clinical utility. First, the online assessment battery demonstrated clinical utility by affording the clinical researchers the opportunity to begin to conceptualize, plan, and target specific areas when it came time for the interview. The online assessment platform also allowed for widespread dissemination, which was highly desirable in this case, as a method of quickly and efficiently reaching students. Additionally, the efficiency of the computer administration, scoring, and interpretation phases added to the overall ease of the process itself and, in so doing, the structure proved to be extremely useful.

Of all of the psychological check-up components, the interview itself was thought to represent the greatest clinical utility. Moreover, it was the combination of quantitative

assessment data and in-person interview experience that was believed to be ideal. When each participant presented for their interview, they tended to offer a narrative that was consistent with the results of the initial assessment; however, the narrative and behavioral observations pulled the various pieces of information together and afforded a context and unique history. Participants' narrations also provided descriptive language that was captured in the report and in-person feedback, therefore helping them to understand and internalize the information.

The feedback phase proved its clinical utility by providing each participant with the major findings of their psychological check-up, brief overall conceptual narrative, and individually tailored recommendations for greater adaptive functioning. Common themes included the experience of low relational value, defensively withdrawing and not wanting to "burden" others with their problems, academic stress, and uncertainty about their future career plans. In each case, the clinical researchers provided validation for each participant's strengths and adaptive strategies before presenting new insights. The researchers also offered psychoeducation and described potential new avenues for growth (e.g. recommendations for psychotherapy, bibliotherapy/self-help, and step-by-step methods of realizing one's need for relational value, increasing emotional awareness, etc.) Importantly, all feedback was successfully implemented in a therapeutic atmosphere that was conducive to growth and learning; this was evidenced in the researchers' clinical impressions as well as participants' responses following the psychological check-up experience.

The feedback from participants was judged to be overwhelmingly positive. Specifically, participants indicated that the information contained in their psychological

check-up reports was both useful and meaningful. For example, participants provided responses such as: “[The psychological check-up report] was very meaningful to me. I think it will be very useful to me in the future. It helped me understand myself better” and “Yes, I think it was meaningful. It helped me to think about emotions I suppress which I think made me feel better. Very useful.”

Moreover, all 19 participants reported planning to use the information in an adaptive way, including interest in engaging in therapy and using the information to continue the growth and exploration process. For instance, one participant responded, “I hope to speak with a counselor + will be more in tune w/ what my body/emotions are meaning to tell me.” Another participant showed that he had internalized his conceptualization and planned to implement change on his own: “I might work on my coping skills and be more conscious about how often my body image comes to mind.”

All of the psychological check-up participants indicated positive responses to the brief therapeutic assessment protocol. Specifically, they indicated that the information was accurate, meaningful, and inspired growth or greater understanding of the self. Further, follow-up feedback collected 2 weeks after the informing session showed that all participants considered the experience to be positive in some way. Therefore, based on the above qualitative analysis, the psychological check-up was found to demonstrate both feasibility and utility, as evidenced by participant report and clinical judgment.

The Pilot Version of the Psychological Check-Up Protocol: Areas for Growth

As the clinical researchers implemented part 2 of the current study, the psychological-check up, they frequently consulted about their experiences with the

protocol. In so doing, several points of discussion arose, some of which consisted of logistical concerns and some of which represented areas of potential revision for the future. Those areas of interest are discussed below.

First, recall that in part 2 of the study, the Psychological Check-Up, participants completed the online assessment battery for course credit and were contacted with an invitation to engage in the interview and feedback portions. A problem arose, however, as many participants did not answer that invitation. After 3 unsuccessful attempts, the principal researcher considered the participant to be uninterested. In total, 65 participants completed the online assessment battery in part 2 of the study. Of those 65, only 19 expressed interest in engaging in the interview and feedback stages. Therefore, we are limited in our ability to generalize this protocol to larger populations. Future iterations of the psychological check-up protocol should address this problem by expanding their recruitment. Future protocols might include more widely circulated advertisement or greater incentives. In particular, the protocol might be implemented as part of an initial assessment in a university counseling setting, to ensure more widespread screening and identification of at-risk students. Further, future protocols might include phone contact with interested participants, rather than choosing to rely solely on email as a contact medium. In the current study, email was the sole medium for contacting participants throughout the process, which provided inherent difficulty in terms of greater turn-around time relative to the swiftness of phone contact and the possibility that some students might not regularly check their university email.

Second, there were some concerns related to the measures that were selected for the psychological check-up battery. First, it seemed that our two included “Big 5”

measures, the Newcastle Personality Assessor (NPA; Nettles, 2007) and Ten-Item Personality Inventory (TIPI; Gosling et al., 2003) not only had low internal consistency for some subscales, but also demonstrated suboptimal alternate forms reliability. Whereas the agreeableness, conscientiousness, and neuroticism constructs from one measure were moderately correlated with their corresponding counterparts, the extraversion and openness constructs from each of the two measures were weakly associated (.29 and .25, respectively).

The values and virtues measure (PVQ; Schwartz, Melech, & Lehrnami et al., 2001) was not easily interpreted and not utilized in the interpretation. The PVQ is a 40-item measure that presents short “portraits” of 29 fictional individuals’ goals and wishes. The measure provides a snapshot of those “portraits” and asks participants to consider the degree to which each individual is like or unlike them. After the part 1 normative data was collected, the researchers decided that the psychological check-up battery might have become too lengthy; therefore, we considered each measure with a critical eye. It was determined that, of all of the measures, the PVQ appeared to provide the least clinical information. Given the low clinical utility and length of the measure, as well as the finding that some participants were skipping the measure altogether, it was decided that the PVQ would be cut from part 2: the Psychological Check-Up.

Third, there were pros and cons to interpreting psychological check-up participants’ scores according to that of their peers. Participants’ well-being and character functioning scores were compared to those of other JMU students in a deliberate way, as this afforded the ability to identify those that were considered thriving or not thriving within their current environments. In this way, comparing participants to their peers was

a very practical way of identification and one that modeled a new protocol for “flagging” at risk students. That being said, there was a limitation to interpreting data in this way, as there was the concern that JMU student data did not represent a normal distribution of scores. Specifically, the concern arose that if JMU students were statistically high or low on certain scores, then comparing psychological check-up participants to their peers might lead to a skewed interpretation of their functioning. For example, if the majority of students in our sample endorsed an eating disorder, then a psychological check-up participant’s score for eating behaviors might be interpreted as statistically average as compared to their peers but in reality might be very high by conventional standards. Though it is not the case that JMU students endorsed higher rates of eating disorders, research (Eisenberg, 2013) has shown that JMU students do tend to endorse a higher than average rate of “flourishing” (a construct of well-being) as well as a lower overall depression score, lower anxiety score, lower endorsement of suicidal ideation, and lower academic impairment from mental health concerns. At the same time, JMU students have been found to have higher than average levels of binge drinking and substance use (marijuana, amphetamines, ecstasy, and club drugs, but not opiates). Therefore, by interpreting participant scores only as compared to their peers, those participants who represent certain risks might not trigger a “flag” in areas in which they should. Thus, it is recommended that participant scores continue to be interpreted as compared to those of their peers, while also acknowledging the areas in which a student sample might be higher or lower than other typical samples. Future use of the psychological check-up protocol should also reference normative data for non-student samples and remain mindful of suggested cut-off scores for included measures.

Fourth, throughout the psychological check-up process, the clinical researchers remained mindful of the brief nature of their interactions with participants. Of course, with such a brief protocol, there are inherent risks. Specifically, there was a risk that participants might have become distressed by the questions. They might have also become defensive in response to challenges or suggestions for change. With this in mind, the protocol was developed according to the basic tenets of therapeutic assessment. Thus, in all interactions, the clinical researchers utilized the skills of a clinician conducting a traditional therapeutic session. Each interview session included rapport building and empathic attunement as well as validating and encouraging statements. This relational context was crucial to the process due to the nature of ultimately needing to provide sensitive feedback to participants. Additionally, all participants were assessed for suicide risk and provided with detailed contact information for multiple counseling services available to them.

Fifth, related to the aforementioned point, there was a question of whether participants might become distressed after their feedback sessions when they had time to reread and process the contents of their psychological check-up reports. Due to this concern, we added a 2 week follow-up contact with participants. As such, the clinical researchers contacted their participants via email and provided them with a thank you for their participation and an attached follow-up feedback questionnaire. The main problem with the follow-up feedback process was that many participants did not respond. In fact, only 50% of the psychological check-up participants sent back a completed questionnaire. This problem with email contact at follow-up was consistent with the challenge of not receiving responses from participants contacted for their initial

interviews. Therefore, follow-up feedback responses were interpreted with caution. Of those who responded, participants reported continuing to view their reports to be both accurate and meaningful. They were also asked whether they experienced any adverse reactions and, conversely, any positive reactions, since the time of their feedback sessions. Of the participants who sent back their completed follow-up feedback questionnaires, responses indicated mild discomfort for some participants. For example:

I would not say I have negative emotions about the report, but it definitely made me emotional. Feelings that I shut out came up, and I was forced to think about and talk about things that brought emphasis to some scary things. I am glad I was able to talk about these things, though, because I think I had been holding them in. It definitely made me feel better to get everything out. It is a bit discomforting, just because emotions came up I would rather not feel, but it was nothing I could not handle.

At the same time, every participant who provided follow-up feedback indicated a positive response to their psychological check-up experience. For example:

[The information] inspired me to accept who I am and how I am feeling , to share it with people I trust, and to never be ashamed. As I said before, it helps to have it all laid out for me, because often I feel a million thoughts at once and it is hard to understand myself. I feel more confident with who I am and what I struggle with and I am excited to use the suggested sources to become even stronger. Thank you!

Conclusion

In the current study, a new protocol was developed for assessing and understanding individuals. The Psychological Check-Up protocol offers a comprehensive map of human functioning, taking into consideration individuals' current well-being and overall character structure, effectively integrating major psychotherapeutic paradigms, including behavioral, cognitive, and psychodynamic theories.

The psychological check-up can effectively address the college student mental health crisis because it offers a large-scale method of identifying and intervening with vulnerable individuals in a way that is quick, efficient, and theoretically grounded. Young adults, and college students in particular, appear to struggle with not fully knowing themselves as well as how and why they might be functioning in particular ways. Further, many do not know how to access help. To address these problems, the psychological check-up offers a snapshot of well-being functioning, including current levels of distress and pathology. Perhaps more importantly, participants are also presented with a narrative of their identity, specific trait and relational profiles, defenses, and common behavioral patterns. They are encouraged to understand their unique histories and, in so doing, further develop their identities and self-knowledge. New conceptual insights are presented within a supportive atmosphere and following that process, participants are provided with individually tailored resources to support and facilitate adaptive change.

The fact that the assessment battery was administered online afforded the opportunity to reach a great deal of people in a very short period of time, which was one of the goals of the project itself: widespread dissemination. Additionally, another important hallmark of the psychological check-up was its efficiency. By administering the measures online, participants did not have to wait to schedule an appointment that was convenient for them as well as for a researcher. They could also spend as much or as little time as they would like to complete the measures and in the setting that they preferred. Scoring and interpretation were also efficient processes. Raw data were downloaded and entered into SPSS. A syntax file was generated to easily score participant data and an excel spreadsheet was created to convert participant scores to z-

scores and compare them to normative data. In this way, the clinical researchers were required to spend less time and effort as compared to typical assessment scoring and interpretation procedures. Once the computerized administration and scoring sequence was established and automated, it also drastically reduced the likelihood of human error.

That being the case, automatizing the assessment, scoring, and interpretation processes afforded the clinical researchers the opportunity to reach more people and to spend more time with the individual participant. In fact, the crucial features of the psychological check-up were the in person interview and feedback sessions. Simply put, those sessions allowed for supportive working relationships to develop between individuals (e.g. participant and clinical researcher). In the context of those relationships, challenging material could be shared in a way that was insight- and growth-promoting rather than offensive or punitive. Upon reflection, it is the clinical researchers' belief that the psychological check-up demonstrated both feasibility and utility. Further, participant responses corroborated that belief by indicating that the information that they received was accurate, meaningful, an efficient use of their time, and growth promoting in some way. Therefore, based on their implementation experiences and participants' positive feedback responses, it is also the clinical researchers' belief that the psychological check-up can effectively address the CSMHC.

Implications and Future Directions

The psychological check-up was designed for the purpose of providing meaningful and useful information to college students so that they might become aware of their unique vulnerabilities, increase self-knowledge, and seek adaptive pathways

forward; all of this is in service of addressing the CSMHC. With improved self-knowledge, well-being, and adaptive strategies, it is believed that college students will be better armed to meet the demands that they face as emerging adults.

There were numerous aspects of the protocol that could be improved upon in order to bolster implementation. Those aspects included expanding recruitment, improving the assessment battery by omitting measures with problematic psychometric properties or low clinical utility, using multiple methods of data interpretation, remaining sensitive to the risks of participation (e.g. participants becoming distressed and/or defensive) and consulting with other professionals when needed, and better implementing follow-up contact with participants. It is believed that by addressing these issues, the psychological check-up might become ready for greater and more widespread implementation.

In fact, upon successful implementation of the pilot version of the protocol (which constituted the current study), the clinical researchers worked to apply the changes mentioned above. First, the assessment battery was revised and streamlined. The PVQ was omitted from the list of assessments due to its length and low clinical utility and the PBI was omitted due to reliability concerns. The Six Factor Self-Concept Scale (Stake, 1994) was added to address students' sense of themselves, their individual attributes, and how they are perceived by others. The Six Factor Self-Concept Scale was actually added just before part 2 of the current study began; therefore, part 2 participants did complete the measures, but scores were interpreted based on the Stake (1994) normative data instead of JMU normative data, as the study 1 participants were not administered the measure. After the current study was completed, the Balanced Index of Psychological

Mindedness (BIPM; Nyklicek & Denollet, 2009) was also added to the battery, to assess for students' levels of psychological mindedness, which includes individuals' interest and capacity to reflect on their internal states of being. All other measures included in the current study were retained for future use. With regard to streamlining the protocol, the researchers decided to update and maintain the online version of the psychological check-up while at the same time developing a paper and pencil version and quick scoring sheet. The hard copy version was developed as another administration option.

The psychological check-up has also been implemented in a specific subset of college students: student athletes. During the 2015-2016 academic year, Henriques presented to the JMU athletics department with information about the need for greater student well-being and the ability of the current protocol to assess and address that need. Upon presenting to student athletes, Henriques decided to alter the title to "Well-being Check-Up" as a method of appealing to the student athlete population in a way that had less of a potential for stigma as compared to using the word "psychological." It was at this time that the paper and pencil versions of the Well-being Check-Up (WBCU) and scoring guide were developed for greater ease of use. The study with student athletes is ongoing; therefore, results are not yet available, but data are encouraging at this point.

At this point, the psychological check-up has been streamlined and implemented with student athletes. As such, the clinical researchers are moving forward with their overarching goals of improving the protocol and expanding recruitment and dissemination. Long before the psychological check-up was designed, Henriques envisioned a system of efficiently assessing individuals for their well-being, character, identities, vulnerabilities, and strengths and sharing that information directly with the

individual in a directive and supportive way. With the rise in college student (and young adult) distress, it made intuitive sense to implement the protocol in a population of college students; the current study thus allowed Henriques' vision to begin to come to fruition. Starting with JMU students, the psychological check-up demonstrated its feasibility and clinical utility, according to qualitative analyses (e.g. professional judgment). Thus, future directions for this protocol will need to consist of a) replication in a representative sample of college students to corroborate the current findings, b) outcome studies to determine the effectiveness of the psychological check-up in increasing student self-awareness, subjective experience of utility and meaning, and objective effects on mental health. With regard to the latter point, the current study implemented a follow-up assessment with participants that consisted of collecting their qualitative impressions of the process and its levels of utility and meaning as well as how they might envision using the information in a new way; however, future studies might ask participants to rate their experience quantitatively. Future protocols might also include pre- and post- intervention measures of mental health functioning (e.g. PHQ-9 and GAD-7) and psychological mindedness (e.g. BIPM). Clinical researchers might also follow up on participant functioning at multiple time points (e.g. at 2-weeks, 1-month, and 6-months post intervention, for example). Finally, future directions should also include more widespread dissemination, both with regard to within the current college population and expanding to include multiple university populations. In this way, researchers can assess the feasibility, utility, and effectiveness of the psychological check-up protocol in a larger sample of JMU students as well as in samples of other universities. With regard to the latter point, student well-being and character functioning

can be compared between university settings, geographical locations, and differing environmental factors (e.g. socioeconomic status, academic rigor, etc.). At the same time, the clinical researchers could reach a greater number of college students, which is a step toward the goal of further addressing and assessing the CSMHC.

Appendix A

The Psychological Check-Up: A Normative Study

Are you interested in participating in a psychological research study for course credit?

We are interested in volunteers to help us collect information about the JMU student population. We are collecting information via measures of personality traits, ego functioning, relational strategies/relational value, attitudes, coping self-efficacy, positive and negative affect, and a global measure of distress/symptoms. These will then be analyzed and interpreted via Gregg Henriques' unified approach to character and well-being. All responses will be kept completely confidential.

Each interested student may click the first weblink provided below, which links to an informed consent form. After you read and understand the risks and benefits of participating, please type your name to indicate that you consent to participate. When you do, a second weblink will be provided, which will take you to the survey and assessment battery. If you do not consent to participate, you will not be provided with that second link.

Link to Informed Consent Form:

http://jmu.co1.qualtrics.com/SE/?SID=SV_3atp2I5LDGwmYRL

Appendix B:

Informed Consent for Psychological Check Up: A Normative Study

Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by *Lindsay Anmuth, MA* and *Gregg Henriques, PhD* from James Madison University. The purpose of this study is to understand well-being, adaptation, and interpersonal functioning by offering a “psychological check-up.” Part of that checkup includes filling out questionnaires, which need to be normed on the JMU population. This study is a component of Lindsay Anmuth’s doctoral dissertation at James Madison University.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an online assessment. You will be asked to provide answers to a series of questions related to your mood, your personality and identity, and various domains of current functioning, which include your daily habits, experiences, thoughts, and relationships.

Time Required

Participation in this study will require approximately 75-90 minutes of online survey responding. By signing this consent form, you are agreeing to participate in this “psychological check-up.”

Risks

The investigator perceives that the following possible risks might arise from your involvement with this study: You will be asked to respond to how you feel about yourself, your functioning and your emotions, thus you may experience some mild discomfort in doing so.

Benefits

There are no foreseeable benefits to you specifically. The benefits go into the general development of a psychological checkup for college students.

Confidentiality

You will not provide any identifying information. Thus your results will be completely confidential and the results of the project will only be reported in terms of aggregate data. All data will be stored in a secure location accessible only to the researchers.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of

any kind. However, once your responses have been submitted and anonymously recorded you will not be able to withdraw from the study.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion, or you would like to receive a copy of the final aggregate results of this study, please contact:

Lindsay M. Anmuth, MA
Department of Graduate Psychology
(Director)
James Madison University
AnmuthLM@jmu.edu

Gregg R. Henriques, PhD
Department of Graduate Psychology
James Madison University
henriqgx@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley
Chair, Institutional Review Board
James Madison University
(540) 568-2834
cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I read, understand, and consent to participate in this study. (Please write your name below). _____

☐ I do not consent to participate in this study.

Appendix B:

Informed Consent for Psychological Check-Up

Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by *Lindsay Anmuth, MA, Gregg Henriques, PhD, and Jennifer Mills, MA* from James Madison University. The purpose of this study is to enhance self-awareness, well-being, adaptation, and interpersonal skills by offering a well-being “check-up.” This study will act in service of Lindsay Anmuth’s doctoral dissertation at James Madison University.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an online assessment, brief individual interview, and feedback session. *All interviews will take place in the counseling suite located on the ground floor of James Madison University’s Miller Hall.* You will be asked to provide answers to a series of questions related to your mood, your personality and identity, and various domains of current functioning, which include your daily habits, experiences, thoughts, and relationships.

Time Required

Participation in this study will require approximately 1.5 hours of online survey responding followed by a 30-minute in-person interview and a subsequent 30-minute feedback session about your functioning. By signing this consent form, you are agreeing to participate in this well-being “check-up,” which is expected to require approximately 2.5 hours of your time.

Risks

The investigator perceives the following are possible risks arising from your involvement with this study: The nature of this intervention is to assess and discuss various areas of your functioning and, as such, there is a potential risk of becoming overwhelmed or distressed.

Benefits

Potential benefits from participation in this study include fostering a greater understanding of the self and in-depth feedback about your functioning along various domains of adaptation and well-being as well as recommendations and information about potential resources for fostering personal growth. All of the aforementioned benefits are offered to you free of charge.

Confidentiality

The results of this research will be presented as part of a doctoral dissertation as well as conference presentations; however, the results of this project will be coded in such a way

that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researchers. Upon completion of the study, all information that matches up individual respondents with their answers will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion, or you would like to receive a copy of the final aggregate results of this study, please contact:

Lindsay M. Anmuth, MA
Department of Graduate Psychology
(Director)
James Madison University
AnmuthLM@jmu.edu

Gregg R. Henriques, PhD
Department of Graduate Psychology

James Madison University
HenriqGX@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley
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(540) 568-2834
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Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

Name of Participant (Printed)

Name of Participant (Signed)

Date

Name of Researcher (Signed)

Date

Appendix C

Initial Instructions and Demographic Questionnaire

Thank you for your willingness to participate in this study. Please take your time to answer each question **thoughtfully** as your responses will help progress our understanding of psychological well-being and adaptation. The following survey should take approximately 75-90 minutes. **If you need to temporarily exit the survey, you may do so and resume where you left off, but only by accessing the survey again from this computer.** Your progress will only be saved on the computer from which you first accessed it (Note: computers in JMU Computer Labs may not save your progress, thus it is best to use a personal computer if you wish to exit the survey before completing it).

- 1) How old are you? (Note: you must be at least 18 to participate in this survey)
- 2) What year of college are you currently completing?
- 3) What is your gender?
- 4) What is your marital status?
- 5) What is your ethnicity?
- 6) What was the highest educational attainment of either parent?
- 7) Please describe your level of religiosity.
- 8) Describe your current financial situation
- 9) Describe your financial situation growing up.
- 10) Describe your current relationship status.
- 11) How would you characterize your sexual orientation?

Appendix D

The H10WB (10 min)

Age (Yrs):_____ Sex: Male / Female

Below are a series of ten statements that describe an attribute associated with your life and functioning and then describe the low and high ends of that attribute. Please read each item carefully, and then circle the appropriate number on the scale ranging from one to seven indicating where you fall on that attribute. Respond to the item based on how you have generally felt during the past month. There are no right or wrong answers, so just answer as honestly as you can.

1. Please rate your overall satisfaction with your life. An individual with high life satisfaction feels pleased with most major domains, is at peace with the past, and generally feels fulfilled and content. In contrast, someone with low life satisfaction often wishes things were different, experiences problems in several major areas, and often feels dissatisfied, alienated, or unfulfilled.

1. Very low in life satisfaction
2. Low in life satisfaction
3. Somewhat low in life satisfaction
4. Neutral or sometimes high and sometimes low in life satisfaction
5. Somewhat high in life satisfaction
6. High in life satisfaction
7. Very high in life satisfaction

2. Please rate your sense of mastery over the environment, which is the degree to which you feel competent to meet the demands of your situation. Individuals high in environmental mastery feel they have the resources and capacities to cope, adjust and adapt to problems, and are not overwhelmed by stress. Those with a low level of environmental mastery may feel powerless to change aspects of their environment with which they are unsatisfied, feel they lack the resources to cope, and are frequently stressed or overwhelmed.

1. Very low in environmental mastery
2. Low in environmental mastery
3. Somewhat low in environmental mastery
4. Neutral or sometimes high and sometimes low
5. Somewhat high in environmental mastery
6. High in environmental mastery
7. Very high in environmental mastery

3. Please rate your degree of emotional health. Someone who is functioning well in this domain is able to experience the full range of emotions, is comfortable with their feelings, and generally feels more positive as opposed to negative emotions (i.e., more joy and excitement relative to frustration and anxiety). In contrast, someone who is having trouble in this domain has difficulty in effectively connecting with their emotions, often feels overwhelmed or afraid of their emotions, and tends to feel more negative than positive emotions.

1. Very low in emotional health
 2. Low in emotional health
 3. Somewhat low in emotional health
 4. Neutral or sometimes high and sometimes low in emotional health
 5. Somewhat high in emotional health
 6. High in emotional health
 7. Very high in emotional health
4. Please rate the overall quality of your relationship with others. An individual with positive relationships feels connected, respected, and well-loved. They can share aspects of themselves, experience intimacy, and usually feel secure in their relations. In contrast, individuals with poor relationships often feel unappreciated, disrespected, unloved, disconnected, hostile, rejected, or misunderstood. They tend to feel insecure and sometimes alone or distant from others.
1. Very poor relations with others
 2. Poor relations with others
 3. Somewhat poor relations with others
 4. Neutral or sometimes positive and sometimes negative
 5. Somewhat positive relationships with others
 6. Positive relations with others
 7. Very positive relations with others
5. Please rate your sense of autonomy. Individuals with high levels of autonomy are independent, self-reliant, can think for themselves, do not have a strong need to conform, and don't worry too much about what others think about them. In contrast, individuals low in autonomy feel dependent on others, are constantly worried about the opinions of others, are always looking to others for guidance, and feel strong pressures to conform to others' desires.
1. Very low in autonomy
 2. Low in autonomy
 3. Somewhat low in autonomy
 4. Neutral or sometimes high and sometimes low
 5. Somewhat high in autonomy
 6. High in autonomy
 7. Very high in autonomy
6. Please rate your levels of self-acceptance, which refers to the degree positive attitudes you have about yourself, your past behaviors and the choices that you have made. Someone with high self-acceptance is pleased with who they are and accepting of multiple aspects of themselves, both good and bad. In contrast, individuals with low self-acceptance are often self-critical, confused about their identity, and wish they were different in many respects.
1. Very low in self-acceptance
 2. Low in self-acceptance
 3. Somewhat low in self-acceptance
 4. Neutral or sometimes high and sometimes low
 5. Somewhat high in self-acceptance
 6. High in self-acceptance
 7. Very high in self-acceptance

7. Please rate your levels of satisfaction with your academic functioning. This refers to how happy you are with your academic performance, what you are learning and your sense that it is preparing you for a fulfilling career. Individuals highly satisfied with their academic functioning are pleased with the grades they get, enjoy the material they are learning and are hopeful about how this is preparing them for future careers they will find fulfilling. In contrast, those dissatisfied with their academic functioning are struggling to get the grades they desire, are frustrated with either what they are learning or their ability to learn the material and are confused, disappointed or anxious about their future career opportunities.

1. Very low in satisfaction with academic functioning
2. Low in satisfaction with academic functioning
3. Somewhat low in satisfaction with academic functioning
4. Neutral or sometimes high and sometimes low in satisfaction with academic functioning
5. Somewhat high in satisfaction with academic functioning
6. High in satisfaction with academic functioning
7. Very high in satisfaction with academic functioning

8. Please rate your levels of satisfaction with your health and fitness. This refers to how happy you are with your bodily health and fitness levels. An individual high in health and fitness does not have chronic health problems, is physically fit, and feels comfortable with their bodies and physical functioning. In contrast, a person who is low in health and fitness experiences chronic health problems, does not have healthy eating, sleeping or exercise patterns, or feels deeply dissatisfied with their bodies or physical functioning.

1. Very low in satisfaction with health and fitness
2. Low in satisfaction with health and fitness
3. Somewhat low in satisfaction with health and fitness
4. Neutral or sometimes high and sometimes low in satisfaction health and fitness
5. Somewhat high in satisfaction with health and fitness
6. High in satisfaction with health and fitness
7. Very high in satisfaction with health and fitness

9. Please rate the level of your sense of purpose in life. Individual with a high sense of purpose sees their life has having meaning, they work to make a positive difference in the world, and often feel connected to ideas or social movements larger than themselves. Such individuals have a sense that they know what their life is about. Individuals low in this quality often question if there is a larger purpose, do not feel their life makes sense, and attribute no higher meaning or value to life other than the fulfillment of a series of tasks.

1. Very low in sense of purpose
2. Low in sense of purpose
3. Somewhat low in sense of purpose
4. Neutral or sometimes high and sometimes low
5. Somewhat high in sense of purpose
6. High in sense of purpose
7. Very high in sense of purpose

10. Please rate your level of personal growth. Individuals with high levels of personal growth see themselves as changing in a positive direction, moving toward their potential,

becoming more mature, increasing their self-knowledge, and learning new skills. Individuals low in personal growth feel no sense of change or development, often feel bored and uninterested in life, and lack a sense of improvement over time.

1. Very low in personal growth
2. Low in personal growth
3. Somewhat low in personal growth
4. Neutral or sometimes high and sometimes low
5. Somewhat high in personal growth
6. High in personal growth
7. Very high in personal growth

Appendix E

INFLUENCE MATRIX-SOCIAL MOTIVATION Short Form
ITEMS BY SUBSCALE

The following set of questions deals with how you feel about yourself and your relationships. Please rank each question on a scale of 1 to 5, with a 1 being strongly disagree and a 5 being strongly agree. Please remember that there are no right or wrong answers.

Strongly Disagree	Disagree	Mixed/Neutral	Agree	Strongly Agree
1	2	3	4	5

Dominance:

- I tend to be a leader rather than a follower.
- Other people have told me I am assertive.
- I am more dominant than most.
- I don't hesitate to tell people what is on my mind.

Submissiveness

- I tend to give in to what other people want.
- In arguments with others, I tend to submit quickly.
- Other people can control me pretty easily.
- I am easily defeated in social conflicts.

Affiliation

- I enjoy taking care of other people.
- Other people know they can count on me to help.
- I empathize easily with the feelings of others.
- Making others happy makes me feel good.

Hostility

- I am more hostile than most.
- I can be mean and insensitive.
- There are some people I hate.
- I am sometimes aggressive toward others.

Autonomy

I am more independent than most.
Other people do not have much influence over the decisions I make.
What other people say doesn't bother me.
I can accept rejection or disapproval from others without being too upset.

Dependency

I depend on others a lot for guidance and assistance.
I try hard to get other people to like me.
I crave the approval and acceptance of others.
I worry a lot about what other people think of me.

High Relational Value/Social Influence

I have many close, meaningful relationships.
I am well-loved by my family.
I am known and valued by important others in my life.
I am admired and well-respected by my peers.

Low Relational Value/Social Influence

Other people often ignore me.
I don't feel as valued or respected as I would like.
I have difficulties relating to others.
I don't have as many close relationships as I would like.

Appendix F

Study 2 Standardized Email Contact Message

Good afternoon.

Thank you for your participation in our study entitled “Who am I and How am I doing? A Psychological Check-Up: Part 1.” You are being contacted because you completed the study and are now eligible to participate in Part 2 of the study, if you so choose. If you decide to participate, you will receive 2 additional credits, giving you a total of 3 research credits.

Part 2 involves 2 phases. Phase 1 will require you to attend a 45-minute meeting with one of the 3 researchers, during which we will conduct an interview and get to know you much better. We will talk to you about the results of your part 1 “Psychological Check-Up” and gather more information. After that, we will put all of that information together and create a short written report about your well-being and functioning in a wide variety of areas. We will then ask you to meet with us 1 more time (for about 30 minutes) during which time we will share the written report and discuss your results with you, including recommendations for greater health and well-being. This affords you the unique opportunity to gain an in-depth picture of who you are and how you are doing. Importantly: it is both brief and free to you.

If you are interested in participating, please contact anmuthlm@jmu.edu.

If you would like to receive 2 credits for your participation, please sign up for Part 2 of the study on the JMU participant pool SONA website.

If you would like to participate and do not wish to receive the 2 credits, just simply contact the email address above.

Thank you very much for your participation. We hope to hear from you and to work with you in the near future.

Take care.

Lindsay Anmuth

Appendix G

A Semi-Structured Interview as part of a Psychological Check-Up

The goal in the semi-structured interview is to assess the key pieces of a person's life and functional repertoire to be able to construct a narrative of how they got to where they are, their strengths and limitations, as well as areas that tend to result in neurotic or maladaptive patterns, which in turn should give rise to notions about how their story might unfold in the future in a more adaptive way.

I. *Setting the Frame for the Check-up.* Prior to diving into the major domains assessed in the clinical interview, it is crucial to set the appropriate frame of understanding. This involves making sure both parties (you and the client) are clear about the purpose of the evaluation, the nature of the evaluation and final product (e.g., amount of testing, the nature of the write up and kind of information included), and the paperwork, informed consent, costs, and time line to completion.

II. *An overview of well-being and life satisfaction.* After setting the frame, it is often useful and appropriate to begin the interview with the individual reflecting on how she feels her life is going and her overall degree of life satisfaction.

1. My goal is to get a picture of how you are functioning in different domains and your levels of well-being. Let's start broadly. How would you say things are going overall for you?
2. How satisfied are you with your life right now? What are the areas that are going the best? What are the areas that are not going so well?
3. From the surveys you filled out, it seemed your overall well-being was in the (low, somewhat low, somewhat high, high, very high) range and that compared X with other students. Does that sound right to you? Are you surprised that you were X relative to others?)

III. *An Exploration of Potential Problems.* Follow up on any domains in which the individual expressed concerns or problems with questions such as:

1. When did the problem start? Are the problems chronic or acute? (months, years or decades?)
2. Were the current problems associated with a specific triggering event or did they emerge more gradually?
3. Under what circumstances and contexts does she have the most difficulty; when is she the most functional?
4. How serious is the problem and how important is it to be resolved?

5. What does the individual believe to be the major causes, and does she interpret it getting better or worse?
6. Has the individual had an evaluation or received treatment for this problem before?

III. *Personality and Socio-emotional Functioning.* Personality and socioemotional functioning refers to the individual's temperament, characteristic ways of responding to the environment, and identity. Below is a list of questions that get at these domains. For each domain, the interviewer should have looked at the quantitative survey data and highlighted areas to explore in more depth.

- A. *Habits and Daily Activities.* This domain refers to the daily activities and patterns of behavior that the individual engages in. Common domains to assess include:
 1. Patterns of sleep and wakefulness (# hours, naps, ease falling or staying asleep)
 2. Eating (regularity of meals, restrictive or overeating, unusual or unhealthy diet)
 3. Substance use (frequency, intensity and duration of nicotine, alcohol, and illicit substance use)
 4. Sexual frequency and levels of satisfaction or conflict
 5. Exercise (frequency of exercise, degree of physical fitness)
 6. Regularity of routine; daily stressors (e.g., noise)
 7. Hobbies, interests, leisure time
- B. *The Experiential System.* This domain refers to the embodied phenomenological state (i.e., the felt experience of being). It is organized by affect, although includes perceptions, drives, and images. Common domains to assess include:
 1. Can the individual "get in touch" with his feelings?
 2. What is the general degree of emotionality?
 3. Is the individual able to stay centered and mindful of what is happening at the experiential level?
 4. Can the individual express her feelings effectively? Does the individual have trouble with experiencing all or some emotions? Are there secondary emotions that are covering up primary emotions?
 5. Are there dominant emotional states that are chronically active/accessible, emotions that are expansive or under regulated? What about emotions that are over controlled?
 6. Does the individual day-dream or experience strong images or flashbacks?
 7. Does the individual have gut feelings or a sense of things being either good or off?
 8. Is there harmony or alienation between the self-consciousness system and the experiential system?

- C. *The Relational System.* This domain refers to the internal working models or self-other schema the individual has developed to navigate the social environment. Common domains to assess include:
1. What is the person's social barometer or sense of relational value...to what extent do they feel generally respected, admired, loved and appreciated as opposed to neglected, rejected and criticized?
 2. Does the individual generally feel secure in her relationships? Do they have issues with trusting others and do they ever get paranoid? Do they have intimate connections with others? Have they had a lot of relationship failures?
 3. Is the individual more agentic (self-focused, concerned with power and autonomy) or more communal (other focused, concerned with affiliation and connection)?
 4. How does the individual handle conflict? Are they aggressive, assertive or submissive? Do they adopt a fairly agreeable or hostile stance in relationship to others?
 5. Are they particularly sensitive to criticism or rejection? Do they fear abandonment? Do they have trouble being alone?
 6. Do they experience conflict between relationship motives of power and love or autonomy and dependency?
- D. *The Defensive System.* This refers to the general harmony between the systems, the filtering between self-conscious and subconscious processes, and processes like cognitive dissonance and psychodynamic defense mechanisms. Common domains to consider include:
1. Does the individual seem guarded, hesitant to disclose, resistant to elaborating on all or certain elements of their story?
 2. Do they get words or body language in response to certain questions?
 3. How do they cope when they feel stressed?
 4. Do they engage in rationalizations or suppression/repression or other similar processes?
 5. Do they demonstrate good insight and are they able to reflect on what drives them? Or does such conscious self-reflection activate anxiety and a closed off response?
 6. Do they seem to avoid some topics or some emotions? (levels of experiential avoidance)
- E. *The Justification System.* This refers to the self-conscious, language-based belief-value networks that individual uses to make meaning out of his world, and to consciously understand himself and others. In regards to assessing the justifying self, cognitive and narrative therapies allow a lens to view aspects of this portion of the psyche. Thus, thinking about the individual's justification narrative (the story

they have about themselves in relationship to the world) and automatic thoughts/inferences/core beliefs are useful concepts to bring to bear in understanding this domain. More specific elements include:

1. What is the general functioning of their verbal system (VCI)? Vocabulary usage, complexity of sentences, social comprehension of norms, etc.
2. What is the level of ego development? Do they reflect on who they are and why? Are they able to give complex, textured answers to reflective questions or are they brief and underdeveloped? Or are they limited in terms of verbalizing, don't think much about their identity, etc.?
3. What is the degree of self-regulation and self-control? What is their level of conscientiousness and the need for control? Do they exhibit a lot of self-discipline or are there problems with impulsivity? Can they direct themselves toward long term goals?
4. Do they engage in a lot of self-criticism and negative self-talk? Is there an internalized parental voice constantly judging them? Do they have core beliefs about self that are negative?
5. What is their general level of self-efficacy? Do they perceive themselves as resilient or weak?
6. What is their driving purpose in life? Do they connect to a higher power or follow particular religious teachings? Do they care about politics or have active views/philosophies regarding how the world works? Are they concerned with their own local reality or do they reflect on where values come from, where the country (or world) should be headed?
7. Are they known to others or do they frequently filter their private thoughts from their public thoughts?
8. What is the individual's overall degree of life satisfaction?

IV. *DSM Diagnostics and Mental Status Screen.* If the presenting problem is a cluster of symptoms associated with a major diagnostic category, the relevant symptoms should be explored. For example, if the individual clearly reports symptoms of depression, then assess for anhedonia, feelings of sadness/despair, loss of energy, etc. If AD/HD, then assess for problems with organization, procrastination, day-dreaming, impulsivity, history of such problems, and so on. Also, if there is reason to suspect impaired mental functioning or odd responses are given, an interviewer should be prepared to screen the client's mental status. This involves assessing the individual's orientation (to time, person, place and purpose), memory, thought content and process, affect, appearance, attention, speech, and rapport.

V. *Medical History/Biological Context.* Mental functioning is dependent on an intact nervous system. Poor mental functioning/mental disorders can stem from breakdowns in nervous system functioning. Moreover, illness or injury can

greatly impact psychological functioning and overall quality of life. Some common questions that frame this domain are:

1. Has the individual had a recent medical check-up?
2. Has the individual ever had a psychiatric/psychological evaluation? Ever been diagnosed with a mental disorder?
3. Is the individual suffering from a chronic disease?
4. Has the individual been hospitalized? Has the individual experienced a head injury?
5. Does the individual regularly experience bodily pain? If so, where, how long how intense?
6. Is there a history of mental or physical illness in the family?
7. Does the individual have odd symptoms or experience mental symptoms that feel disconnected from reality?
8. Medications, current and past

VI. *Distal Developmental Context.* The distal developmental context is the context in which the individual grew up, with key elements being his relationship with his family of origin, his relationship with peers, crucial formative events, and major successes and failures. Common questions that come to mind are:

2. Was the family intact or not? Were their major disruptions of connections? Was the family enmeshed or distant? How were the children disciplined? (physical?) How was emotion expressed?
3. What was their relationship with their parents? What was the nature of the attachment...secure, avoidant/counter-dependent, anxious/dependent, ambivalent?
4. How was the transition from childhood to adolescence?
5. What was the individual's history of romantic relationships? Sexual identity?
6. Did the individual have a lot of friends? A best friend? Did they feel well-liked or popular in school?
7. Ask them to share a major or formative event that had a long standing impact.
8. Questions about socioeconomic status, parent involvement, effectiveness in school, levels of happiness, etc. are all reasonable
9. Any history of trauma?

VII. *Sociocultural and Relational Contexts.* It is next important to consider the macro-level societal context. These are the large scale justification systems that play a crucial role in specifying one's place/role/function in the larger society. When thinking about this context, consider the following: What are the large scale beliefs and values that are driving the enterprise? Who is the patient and why? What power is given to the doctor? What social control mechanisms are operating? What are the relevant policies and procedures that are the general shared stories that guide how everyone (including us!) is making sense out of the situation? Some common domains to consider are:

1. Gender
2. SES
3. Racial/Ethnic/Cultural Traditions
4. Religious background and current affiliation
5. National and Regional (e.g., US, Southerner)
6. Political
7. Sexual orientation and attitudes
8. Policies and Procedures

Then consider how the individual is in relational contexts. It is crucial to consider both how is he/she in relation to these individuals and what is his/her overall level of functioning relative to his interpersonal context and prior functioning. Common relational figures are:

1. Mother
2. Father
3. Siblings
4. Extended family members
5. Friends, especially best friend
6. Dating/Romantic Partners/Significant Others
7. Peers, fellow students, co-workers

VIII. *Academic/Occupational Functioning.* This refers to the individual's performance and satisfaction with their academic or occupational functioning. Here we want to understand the individual's history of achievement, areas of success and difficulty, attitude, motivation and investment, and future expectations and desires. Some common questions and domains to consider are (note, focus here is mostly on academics):

1. What were their grades in elementary, middle and high school?
2. What is their current GPA in college? Has it changed much?
3. What were their scores on the SATs?
4. What are their study habits? How long do they study, when, where, what system do they use?
5. What are their best and worst subjects or academic abilities?
6. Do they procrastinate? Do they have trouble organizing? How do they perform on tests?
7. What is their attitude about school? Have they ever been a disciplinary problem?
8. What are their long term career goals? What drives them in that direction?
9. What is the strength of their achievement motivation?

Appendix H

Feedback Questionnaire

Thank you for your participation in this study. We would appreciate it if you took the time to voluntarily answer questions about your experience. Each question is detailed below and we ask that you provide as much information about your experience as possible. Your feedback will help us to ensure that we offer quality services to all participants involved. Thank you!

1. Do you feel as though your report described you accurately or did it seem to fit for you?
2. Do you feel that the information contained in your report added to your sense of knowledge about yourself?
3. Was the information that you were given meaningful to you? Did you find it useful?
4. How do you feel about the amount of time that you spent throughout this process? Do you feel that it required too much time? Too little (you would like to spend more time, get more information)?
5. In what ways do you think you might use the information that you were provided about yourself?

Appendix I

Feedback Questionnaire – Short-term Follow-up

Thank you for your participation in the “Psychological Check Up” study. We would appreciate it if you took the time to voluntarily answer questions about your experience. Each question is detailed below and we ask that you provide as much information about your experience as possible. Your feedback will help us to ensure that we offer quality services to all participants involved. Thank you!

1. Now that you have had time to reflect on the results that were presented to you, how do you feel how accurately your report described you?

2. Was the information that you were given meaningful to you? In what ways have you used the information or in what ways do you plan to use the information?

3. Have you experienced any negative reactions to the information that was presented to you? Have you experienced any discomfort?

4. Have you experienced any positive reactions to the information that was presented to you? Have you felt that it has inspired any self-growth experiences?

Appendix J: Case Study #1- “Anna”

Participant: 4280

Date of Feedback Session: REDACTED

Researcher/Clinician: Lindsay Anmuth, MA



The Psychological Check-Up

The purpose of this evaluation was to conduct a psychological “check-up,” which is designed to offer you an assessment of your psychological well-being, personality traits, identity, and adaptive tendencies. We have gathered information through surveys and an in-person interview and seek here to share with you the major findings and offer you a narrative of your overall functioning.

Major Finding #1: Your psychological well-being was found to be in the average range, relative to other college students.

Psychological well-being refers to the extent to which one is satisfied with their life, is able to control their environment, has positive relations, and the extent to which they tend to experience positive relative to negative emotions. According to results, your overall level of well-being is likely in the average range. Aspects of your life that you rated high are your level of self-acceptance and personal growth. Some areas in which you could improve are your level of health and physical fitness, relationships with others, and emotional health.

Major Finding #2: You appear to be an independent, self-reliant, and driven person.

Over the course of your life, you have become a resilient and independent person. You have attempted to meet your own needs, to refrain from relying on others, and to manage your stress through achieving at a high academic level and controlling your environment. On the one hand, these are positive qualities; however, on the other hand, you might have become less in touch with your own needs and emotions. You shared that it is difficult for you to acknowledge your own negative emotion. You also stated that you have become significantly overwhelmed in the past. At times, you potentially motivate yourself to achieve through feeling guilty and as if you have not worked hard enough.

Major Finding #3: Your style of coping has potentially left you disconnected from others and from your relational needs.

You indicated that when you experience negative emotion, you tend to hide it from others. You are often physically disconnect and spend time alone. On the one hand, as an introverted individual, you appear to be satisfied with the amount that you socialize with others. However, on the other hand, you described a desire to become closer with others, but that you are cautious and it takes a while for you to “let people in.” In this way,

although getting closer to others would be both anxiety-provoking and new, you indicated that at times you wish you could allow others to see the real you.

In order to ensure that you have a true support network around you, you might consider sharing more of your internal experience with others. By allowing yourself to acknowledge all of your emotions, not just positive emotions or those that are easier to feel, you might come to better understand the ways in which you work. In this way, you can relax and not have to filter your own thoughts and emotions. When that happens, you can begin to develop an accurate understanding of who you truly are (e.g. your identity).

A Brief Historical Narrative of Key Events

Developmentally, you shared that you were a quiet child. You recall making friends during your 4th grade year but that you subsequently moved away and were not able to establish another strong friend base. You shared that the move was particularly difficult for you because you were now living with your mother and found your relationship with her to be a challenging one. While you have always known that your mother cares for you, you also shared that she tends to prioritize her own needs and to react with negative emotion at times. This was particularly difficult for you during adolescence. At that time, you shared that your mother showed frequent irritability and criticism. Potentially, this might provide an explanation for the strategies that you developed at that time, including making sure that you received good grades, becoming very clean, and also beginning to criticize your own body. For some people, feeling as though they cannot connect with important others motivates them to work very hard to please and impress those individuals. In this way, they hope that they might receive the love and understanding that they feel they are missing. This refers to the core need for relational value, which is the degree to which we feel important others know, understand, and value us for who we really are.

At the same time, you might have developed both a desire for recognition and love but also a feeling of mistrust and doubt that others would be able to meet those needs. This might help to explain your high degree of independence as well as the feeling that you “preventatively” distance yourself from other people. On the one hand, this strategy has been very adaptive for you, in your family system as well as in your academic life. On the other hand, though, you could potentially be missing out on the possibility of others fully meeting your needs for recognition and being known, understood, and valued for the “real” you, rather than just for what you have been able to accomplish. As such, you might benefit from acknowledging your own core needs and values and attempting to communicate those to others. You shared that your father is a very supportive and loving person. You might consider the ways in which you have been able to share your experiences with him and work, over time, to generalize those strategies to relationships with other people as well.

Your passion and drive are strengths for you. Something to consider, however, is the degree of pressure that you place on yourself. You shared that you have become significantly overwhelmed with worry about planning, deadlines, and maintaining an

efficient schedule, so much so that, during one instance, you required medical treatment. From your descriptions, it appears that you might motivate yourself through guilt surrounding feelings of not working hard enough. Although this has been motivational, you described a pervasive sense of guilt that you carry with you often and it appears that you do not typically celebrate your accomplishments. Perhaps in addition to forming an understanding of your own needs and true emotional experiences, you might also consider reminding yourself of all that you have achieved, of the talent and passion that you possess, and of the future possibilities that are available to you as a result of those qualities.

Recommendations:

Based on the above formulation of your well-being and character functioning, the following recommendations are made:

1. *Psychotherapy.* You could use a safe place to discuss the distress that you feel as a result of your family situation, to learn methods of socializing with others, and to try out new methods of coping. Therefore, it is appropriate that you consider psychotherapy, which is a relationship with a professional who can explore your identity and relationships and how you feel and process feelings and determine what is adaptive for you and what may not be.

JMU has two places on campus where you might seek support: The Counseling Center, for brief therapy, and Counseling and Psychological Services (CAPS), for a longer-term psychotherapy experience. Contact information and fees are listed below.

Counseling and Psychological Services (CAPS)

\$5 per session for JMU students

601 University Blvd.

Blue Ridge Hall

Harrisonburg VA 22801

Phone: 540-568-1735

<http://www.iihhs.jmu.edu/caps/index.html>

Counseling Center

Free for JMU students

Student Success Center, 3rd Floor

Harrisonburg, Virginia 22807

(540) 568-6552

<http://www.jmu.edu/counselingctr/index.html>

2. *Self-Help.* [In addition, you may want to consider educating yourself about dealing with negative emotions and fostering greater well-being. There are many good books available. Here is one that is applicable to you and grounded in scientific evidence.](#)

Kashdan, T., & Biswas-Diener, R. (2014) *The upside to your dark side*. New York, NY: Harper Collins.

Consider the following points offered below as a brief guide points to consider when understanding your emotional health and psychological well-being:

3. Become in touch with your negative emotions: Emotions are signals to the self that help us monitor our environments and our relationships. They also allow us to determine whether we should approach a situation (or person) or avoid it. The outward expression of emotion is an adaptive tool that allows others to perceive what we are feeling and also allows us to organize our behaviors.
 - a. Maladaptive emotional processes can occur when:
 - i. We are not aware of our own emotions, usually because we are defending against them
 - ii. We are experiencing emotions that are secondary to more primary (core) emotions (such as anger)
 - iii. We act impulsively on emotional signals
 - iv. We begin to use our own emotional expressions to elicit behaviors from others (such as care).
 - v. We have trouble accepting our emotions and have negative thoughts about the feelings that we have, all of which leads to a vicious cycle.
 - b. Adaptive emotional process can occur when we:
 - i. Travel deeper than the emotions that lie on the surface or the emotions that are easier to feel. Try to access your primary emotion, or the emotion that lies at the core of your experience.
 1. Specifically, you might allow yourself to acknowledge and feel the anger or sense of injustice that others have not appropriately met your relational needs.
4. *Alter the way you regulate emotions.* Some individuals tend to under-regulate their emotions, become overwhelmed, and have difficulty managing their fears, anxieties, and behaviors. Other individuals tend to over-regulate their emotions, wherein they do not allow themselves to feel difficult emotions, believe their emotional experience would be too painful, that it would not be accepted by others, or that they would lose control.
 - a. You evidence over-regulation. More often, you tend to over-regulate difficult emotions such as sadness and worry. You would benefit by learning that emotions are natural, evolutionary signals that help us to understand ourselves and our experiences as well as what we do and do not like.
 - b. You would also benefit from opening up and communicating emotions to others. By showing emotions to others, we give them access to our “real” selves and allow them to get to know us.
 - c. By allowing ourselves to recognize and label emotions, we learn that the emotion will not overtake us.

- d. To approach your emotions in a healthy way, you might take these steps:
 - i. Observe your feelings
 - 1. Observe the presence of the emotion and notice how it might be experienced in your body
 - ii. Remember that your emotion is not YOU
 - 1. Having an emotion does not mean that you have to act on it.
 - 2. It does not mean that you have always felt that way or that you will always feel that way.
 - iii. Experience your Feelings
 - 1. Notice that emotions leave and return.
 - 2. Try not to push the emotion out of your awareness.
 - 3. Don't try to distance yourself from feelings or make excuses.
 - 4. Don't try to hang onto those feelings or force them.
 - iv. Embrace your feelings
 - 1. Try to notice them without judging yourself for having them.
 - 2. At that point, you can accept the presence of that emotion.
5. *Recognize your need for relational value.* Although the relationships with the primary caregivers (e.g. parents) form the basis of our relationship system, as we develop and grow, we must interact with and form relationships with many different kinds of people. We monitor our relationships in terms of relational value. Our relational value is the extent to which we are important to other people and other people care about our interests and about us. Relational value is the extent to which we see ourselves as being known and valued by others.
- a. As human beings, we all have a core need for relational value and we get that need met by the important others in our lives.
 - b. In order to deepen your relationships and increase your relational value, you might consider sharing with important others the difficult emotions that you tend to hide.
 - c. By recognizing your relational need, you might also recognize that you would benefit from forming deep friendships on campus. Consider opening up to a friend when you feel overwhelmed with schoolwork or in the event that you experience a conflict.
 - d. Keep in mind that interacting in a new way with others can feel strange and anxiety provoking at first; however, just like working out a new muscle, individuals typically feel stronger and more confident with their new skills over time. All the while, attempt to be as much “yourself” as you can be.

Appendix K: Case Study #2- “Barb”

Participant: 1914

Date of Feedback Session: REDACTED

Researcher/Clinician: Lindsay Anmuth, MA



The Psychological Check-Up

The purpose of this evaluation was to conduct a psychological “check-up”, which is designed to offer you an assessment of your psychological well-being, personality traits, identity, and adaptive tendencies. We have gathered information through surveys and an in-person interview and seek here to share with you the major findings and offer you a narrative of your overall functioning.

Major Finding #1: Your psychological well-being was found to be in the average range relative to other college students.

Psychological well-being refers to the extent to which one is satisfied with their life, is able to control their environment, has positive relations, and the extent to which they tend to experience positive relative to negative emotions. According to results, your overall level of well-being is in the average range. You rated your emotional health as low, which indicates that this is an area in which you could improve. According to your ratings, you feel somewhat satisfied with your life, that you have adequate resources to cope, and that you feel somewhat accepting of yourself, though these might also be areas in which to improve. Aspects of your life that you rated high are your health and physical fitness, relationships with others, your sense of autonomy, and that you feel your life has purpose and that you have and will continue to grow as a person.

Major Finding #2: In your relationships with others, you appear to give up some of your personal power and influence in favor of being a part of the group as well as a good friend.

You value being a good listener and doing for others. It is important for you to socialize and to be a part of a group. These are positive qualities, as you have been able to establish valuable friend groups at home as well as on campus; however, there might also be some negative consequences to this type of relational style. You shared that you feel you are “kind of a pushover.” Indeed, you appear to allow others to take up more “space” in relationships than you do. This is partially due to a bad experience with a friend from your past and is also potentially due to a fear that others will not be able to handle your distress or meet your needs. You indicated that you feel uncomfortable explicitly asking

for attention or recognition from others, though privately you wish that more people would put more effort into checking in with you and letting you know that they care.

Major Finding #3: You might be experiencing some unexpressed emotion as well as low relational value.

Your results suggest that you are likely an emotionally reactive person but also that you tend to suppress or hide negative emotions, such as sadness, fear, or anger. Indeed, you indicated that you have experienced a depressive episode in the past and, since that time, that you have made it an important goal of yours to remain positive and not to burden others with your feelings. As you indicated, there are always people in the world that are worse off than you are. This is a powerful and adaptive statement that allows you to gain perspective when you are feeling down. However, since experiencing a depression yourself, you have motivated yourself to do so through guilt. You shared that at times you become impatient and bothered by even simple things, but that you quickly reframe your negative thoughts to be positive and move on. Potentially, you are covering up a primary feeling of anger and that could either be focused on a sense of injustice that comes from your epilepsy diagnosis or a sense of fear, anger, and vulnerability that comes with not feeling that others know, understand, and value you enough.

You often hide negative emotion from other people in favor of maintaining a “happy face.” This makes things easy on other people, but it also makes it less likely that they will be able to respond to you in an appropriate way. As such, you might feel unsatisfied with some of your interactions with people. You appear to be a bit uncomfortable with sharing private internal experiences, such as how you think and feel about yourself. In the interview, you often stated that you did not want to sound cliché, but you often expressed your more difficult thoughts and feelings through quotes or metaphors.

Because you likely fear the feeling of vulnerability because there is the potential that others might not be able to appropriately meet your needs, you tend to hide the side of you that feels lonely, angry, sad, or overwhelmed. This creates a “vicious circle” wherein you feel disconnected from others, hide parts of yourself from them, and consequently feel that you are not truly known or valued by them. This in turn makes you feel even more disconnected.

In order to ensure that you have a true support network around you, you might want to begin to share more of your internal experience with others. However, you might first want to acknowledge more of your own negative emotions (e.g. fear, anger, or injustice) with yourself.

By allowing yourself to acknowledge all of your emotions, not just positive emotions or those that are easier to feel, you might come to better understand the ways in which you work. In this way, you can relax and not have to filter your own thoughts and emotions. When that happens, you can begin to develop an accurate understanding of who you truly are (e.g. your identity).

A Brief Historical Narrative of Key Events

Developmentally, you were close with your family of origin as well as with friends in your hometown. Indeed, you maintain those relationships today. In 7th grade, you were diagnosed with epilepsy and this came as a shock to you and to your family. What was worse was that, at age 14, one of your medications made you feel depressed and also was not effective in controlling your seizures. This was a particularly traumatic time for you, physically and emotionally. You felt overwhelmed and hopeless and, as a result, the family also became concerned and pained by what you were going through. It was at this time that you began to gain perspective with the realization that there were others in the world that were suffering a great deal more than you were. This realization was effective in pulling you out of your depressed state; however, it also caused you to feel guilty that you had allowed for self-pity and what you perceived to be selfishness. Likely, you then motivated yourself to move forward by using guilt in an instrumental way. As you stated, you have a “super guilty conscience” and that conscience motivates you (through guilt) to be “a more positive person.”

Likely, your relational style did not change but only became further reinforced at this time. Your relational style appears to be one wherein you maintain a focus on other people and their needs, listen often, and attempt to meet their needs yourself. At the same time, you do not tend to ask others for much yourself. When you feel stressed, you talk to your mother or to your friend; however, you appear to be afraid of feeling weak or vulnerable and so you do not share a great deal of negative emotion with others. Further, you acknowledged a core need for recognition and care from others and yet, at the same time, you might also fear that if you let others see that you have that need, that they might not attempt to meet it, or that they might try to meet that need but disappoint you in some way. The pain that comes with those possibilities might be motivating you to maintain your “happy face” around others rather than show negative in addition to positive emotion. Relatedly, you dislike any sort of conflict with others and often allow for others to win, partly because you recognize that, at times, conflict is superficial and damaging (as in the case of your prior experience) and partly because you might be afraid of losing your position within the group. Potentially, in order to ensure that you do not make yourself too vulnerable or jeopardize the amount of relational value that you have with others, you have likely become a less assertive and more easygoing person. On the one hand, this has been a very adaptive strategy for you and has allowed you to maintain multiple groups of friends as well as close relationships with your family. On the other hand, though, you could potentially be missing out on the possibility of others fully meeting your needs for recognition and being known, understood, and valued for the “real” you, rather than just for the positive or convenient side of you. As such, you might benefit from acknowledging your own core needs and values and attempting to communicate those to others, in your own words and without filtering.

In addition, you have clearly shown other adaptive abilities. You maintain your prescribed medical regimen (i.e. medication and visits to the neurologist) in order to control your epilepsy and have been successful for quite some time. You were also able to pull yourself out of a depressive episode by self-motivation, perspective, and reframing

your own negative thoughts. There is the potential that, in order to do so, you have been suppressing a level of anger or injustice; however, the adaptive part of that strategy has been your ability to maintain a brighter mood since that time. You indicate strong values, including close family relationships and your catholic religion and both have been important coping mechanisms for you. Finally, you appear to be a strong and motivated student.

Recommendations:

Based on the above formulation of your well-being and character functioning, the following recommendations are made:

1. *Psychotherapy.* You could use a safe place to discuss your needs and emotions as well as to learn additional skills for emotional awareness, self-acceptance, communication, and assertiveness. Therefore, it is appropriate that you consider psychotherapy, which is a relationship with a professional who can explore your identity and relationships and how you feel and process feelings and determine what is adaptive for you and what may not be.

JMU has two places on campus where you might seek support: The Counseling Center, for brief therapy, and Counseling and Psychological Services (CAPS), for a longer-term psychotherapy experience. Contact information and fees are listed below.

Counseling and Psychological Services (CAPS)

\$5 per session for JMU students

601 University Blvd.

Blue Ridge Hall

Harrisonburg VA 22801

Phone: 540-568-1735

<http://www.iihhs.jmu.edu/caps/index.html>

Counseling Center

Free for JMU students

Student Success Center, 3rd Floor

Harrisonburg, Virginia 22807

(540) 568-6552

<http://www.jmu.edu/counselingctr/index.html>

Consider the following points offered below as a brief guide points to consider when understanding your emotional health and psychological well-being:

2. *Become in touch with your negative emotions:* Emotions are signals to the self that help us monitor our environments and our relationships. They also allow us to determine whether we should approach a situation (or person) or avoid it. The outward expression of emotion is an adaptive tool that allows others to perceive what we are feeling and also allows us to organize our behaviors.
 - a. Maladaptive emotional processes can occur when:

- i. We are not aware of our own emotions, usually because we are defending against them
 - ii. We are experiencing emotions that are secondary to more primary (core) emotions (such as anger)
 - iii. We act impulsively on emotional signals
 - iv. We begin to use our own emotional expressions to elicit behaviors from others (such as care).
 - v. We have trouble accepting our emotions and have negative thoughts about the feelings that we have, all of which leads to a vicious cycle.
 - b. Adaptive emotional process can occur when we:
 - i. Travel deeper than the emotions that lie on the surface or the emotions that are easier to feel. Try to access your primary emotion, or the emotion that lies at the core of your experience.
 - 1. Specifically, you might allow yourself to acknowledge and feel the anger or sense of injustice that others have not appropriately met your relational needs.
3. *Alter the way you regulate emotions.* Some individuals tend to under-regulate their emotions, become overwhelmed, and have difficulty managing their fears, anxieties, and behaviors. Other individuals tend to over-regulate their emotions, wherein they do not allow themselves to feel difficult emotions, believe their emotional experience would be too painful, that it would not be accepted by others, or that they would lose control.
- a. You evidence a tendency toward over-regulation. More often, you tend to over-regulate difficult emotions such as anger, sadness and worry. You would benefit by learning that emotions are natural, evolutionary signals that help us to understand ourselves and our experiences as well as what we do and do not like.
 - b. You would also benefit from opening up and communicating emotions to others. By showing emotions to others, we give them access to our “real” selves and allow them to get to know us.
 - c. By allowing ourselves to recognize and label emotions, we learn that the emotion will not overtake us.
 - d. To approach your emotions in a healthy way, you might take these steps:
 - i. Observe your feelings
 - 1. Observe the presence of the emotion and notice how it might be experienced in your body
 - ii. Remember that your emotion is not YOU
 - 1. Having an emotion does not mean that you have to act on it.
 - 2. It does not mean that you have always felt that way or that you will always feel that way.
 - iii. Experience your Feelings
 - 1. Notice that emotions leave and return.
 - 2. Try not to push the emotion out of your awareness.

3. Don't try to distance yourself from feelings or make excuses.
4. Don't try to hang onto those feelings or force them.
- iv. Embrace your feelings
 1. Try to notice them without judging yourself for having them.
 2. At that point, you can accept the presence of that emotion.
4. *Recognize your need for relational value.* Although the relationships with the primary caregivers (e.g. parents) form the basis of our relationship system, as we develop and grow, we must interact with and form relationships with many different kinds of people. We monitor our relationships in terms of relational value. Our relational value is the extent to which we are important to other people and other people care about our interests and about us. Relational value is the extent to which we see ourselves as being known and valued by others.
 - a. As human beings, we all have a core need for relational value and we get that need met by the important others in our lives.
 - b. You describe that there are aspects of yourself that you typically have not felt comfortable sharing. In order to deepen your relationships and increase your relational value, you might consider sharing with important others the difficult emotions that you tend to hide.
 - c. By recognizing your relational need, you might also recognize that you would benefit from forming deep friendships on campus. Consider opening up to a friend when you feel overwhelmed with schoolwork or in the event that you experience a conflict.
 - d. Keep in mind that interacting in a new way with others can feel strange and anxiety provoking at first; however, just like working out a new muscle, individuals typically feel stronger and more confident with their new skills over time. All the while, attempt to be as much "yourself" as you can be.

Appendix L: Case Study #3- “Chloe”

Participant: 1234(f)

Date of Feedback Session: REDACTED

Researcher/Clinician: Lindsay Anmuth, MA



The Psychological Check-Up

The purpose of this evaluation was to conduct a psychological “check-up,” which is designed to offer you an assessment of your psychological well-being, personality traits, identity, and adaptive tendencies. We have gathered information through surveys and an in-person interview and seek here to share with you the major findings and offer you a narrative of your overall functioning.

Major Finding #1: Your psychological well-being was found to be in the average range relative to other college students.

Psychological well-being refers to the extent to which one is satisfied with their life, is able to control their environment, has positive relations, and the extent to which they tend to experience positive relative to negative emotions. According to results, your overall level of well-being is likely in the average range. You rated your level of health and physical fitness somewhat low, but shared that this was because you recently acquired new knowledge about healthy eating habits and have been attempting to put those into place. Otherwise, you indicated that you are pleased with your academic functioning, relationships, emotional health, personal growth, and self-acceptance and that, overall, you are fairly satisfied with your life in general.

Major Finding #2: As a result of your life experiences, you’ve learned to become a private person, which means that there is a potential for you not to receive sufficient support from others.

You indicated that when you experience a great deal of worry, you tend to hide it from others, with the exception of your mother. While you appear to share most things with others, you might not feel comfortable relying on others to help meet your own needs. This could potentially be influenced by feelings of mistrust or simply by uncertainty about how to ask for what you might need. Although this has not been an area of significant concern for you, it could be a potential risk factor for becoming overwhelmed or disconnected in the future.

In order to ensure that you have a true support network around you, you might want to begin to share more of your internal experience with others. However, you might first want to acknowledge your own negative emotions (e.g. fear, sadness, worry, and mistrust) with yourself.

By allowing yourself to acknowledge all of your emotions, not just positive emotions or those that are easier to feel, you might come to better understand the ways in which you work. In this way, you can relax and not have to filter your own thoughts and emotions. When that happens, you can begin to develop an accurate understanding of who you truly are (e.g. your identity).

A Brief Historical Narrative of Key Events

Developmentally, you shared that you were raised in [REDACTED] with your parents and siblings. You reported that as a child, you were close with both parents but that as an adolescent, you became somewhat emotionally disconnected from your father. In 6th grade, you visited the United States for the first time with your mother and attended school in California for 3 months. You reported mixed feelings about that experience as, academically, your grades began to improve but, at the same time, you also witnessed bullying for the first time.

You have grown up during the time of [REDACTED]'s civil war and, as a result, your life has potentially been impacted in many ways. Like others, your family experienced a decrease in socioeconomic status as your father's business has been repeatedly vandalized. At the same time, due to the political unrest and human rights violations that you witnessed, you began to develop an interest in law. When you were 16, your family decided that you should move to the United States with your older brother, who had moved to pursue an education. You reported feeling hesitant to leave, as you were close with your mother; however, you witnessed your sister's struggle with studying medicine in [REDACTED], which provided a sense of motivation to move. You were the first of your friends to leave the country, though you reported that they have all since moved away. You reported coping with the transition by maintaining daily contact with your mother and shared that you were well received by your new peers. In fact, you reported that you "made best friends right away." You indicated that you were able to assimilate into the culture of the United States while maintaining the cultural ideals with which you have been raised.

Since coming to college, you have felt passionate about pursuing a career in International Affairs and about your involvement with the debate team. You stated that professors and peers have encouraged you to share your background and perspective and that you have felt comfortable doing so. You indicated that you remain informed about what is taking place in [REDACTED] and that you tend to worry at times. You shared that you worry about your parents and other family members; however, you try not to become overwhelmed. When you do feel stressed, you shared that you typically exercise. You reported that you feel comfortable talking with friends, but that you tend not to share the content of your worried thoughts. This hesitation to share could be related to your statement that you feel uncomfortable sharing some of your private thoughts, for fear that people might spread that information to others. Indeed, you indicate witnessing others being mistreated in this way. Because of this, you tend to share your worries with your mother but less often with your friends.

You have evidenced great strength in your ability to tolerate distress, become independent, and adapt to a new culture. You have identified a career path and feel passionate and motivated to help others. You also appear to relate to others and to make friends with ease and to be comfortable sharing most things with them as well as to support them yourself. Some areas that you might want to consider are your levels of potential worry and mistrust of others. You shared that thinking about the violence and unrest in [REDACTED] causes you to worry about your family. This worry appears to be completely warranted. What you might want to consider is whether you feel you have enough support around you as well as an outlet to discuss your concerns. You indicate that you feel mistrustful of others when it comes to sharing very private details; however, you might consider whether there are individuals around you that you might trust enough to share your potential worries, fears, sadness, and concerns. It is realistic to believe that if you have sufficient support around you and feel that others know you, understand you, and value you (e.g. meet your need for relational value), your well-being might further improve.

Recommendations:

Based on the above formulation of your well-being and character functioning, the following recommendations are made:

1. *Psychotherapy.* You could use a safe place to discuss the distress that you feel as a result of the injustices that you have witnessed and worry about your family members, as well as to learn to share more emotion with others. Therefore, it is appropriate that you consider psychotherapy, which is a relationship with a professional who can explore your identity and relationships and how you feel and process feelings and determine what is adaptive for you and what may not be.

JMU has two places on campus where you might seek support: The Counseling Center, for brief therapy, and Counseling and Psychological Services (CAPS), for a longer-term psychotherapy experience. Contact information and fees are listed below.

Counseling and Psychological Services (CAPS)

\$5 per session for JMU students

601 University Blvd.

Blue Ridge Hall

Harrisonburg VA 22801

Phone: 540-568-1735

<http://www.iihhs.jmu.edu/caps/index.html>

Counseling Center

Free for JMU students

Student Success Center, 3rd Floor

Harrisonburg, Virginia 22807

(540) 568-6552

<http://www.jmu.edu/counselingctr/index.html>

Consider the following points offered below as a brief guide points to consider when understanding your emotional health and psychological well-being:

2. *Become in touch with your negative emotions:* Emotions are signals to the self that help us monitor our environments and our relationships. They also allow us to determine whether we should approach a situation (or person) or avoid it. The outward expression of emotion is an adaptive tool that allows others to perceive what we are feeling and also allows us to organize our behaviors.
 - a. Maladaptive emotional processes can occur when:
 - i. We are not aware of our own emotions, usually because we are defending against them
 - ii. We are experiencing emotions that are secondary to more primary (core) emotions (such as anger or injustice)
 - iii. We act impulsively on emotional signals
 - iv. We begin to use our own emotional expressions to elicit behaviors from others (such as care).
 - v. We have trouble accepting our emotions and have negative thoughts about the feelings that we have, all of which leads to a vicious cycle.
 - b. Adaptive emotional process can occur when we:
 - i. Travel deeper than the emotions that lie on the surface or the emotions that are easier to feel. Try to access your primary emotion, or the emotion that lies at the core of your experience.
 1. Specifically, you might allow yourself to acknowledge and feel the anger or sense of injustice that others have not appropriately met your relational needs.
3. *Alter the way you regulate emotions.* Some individuals tend to under-regulate their emotions, become overwhelmed, and have difficulty managing their fears, anxieties, and behaviors. Other individuals tend to over-regulate their emotions, wherein they do not allow themselves to feel difficult emotions, believe their emotional experience would be too painful, that it would not be accepted by others, or that they would lose control.
 - a. You might evidence over-regulation. In particular, you might potentially be suppressing feelings of anger, injustice, or worry. You would benefit by learning that emotions are natural, evolutionary signals that help us to understand ourselves and our experiences as well as what we do and do not like.
 - b. You would also benefit from opening up and communicating more emotions to others. By showing emotions to others, we give them access to our “real” selves and allow them to get to know us.
 - c. By allowing ourselves to recognize and label emotions, we learn that the emotion will not overtake us.

- d. To approach your emotions in a healthy way, you might take these steps:
 - i. Observe your feelings
 - 1. Observe the presence of the emotion and notice how it might be experienced in your body
 - ii. Remember that your emotion is not YOU
 - 1. Having an emotion does not mean that you have to act on it.
 - 2. It does not mean that you have always felt that way or that you will always feel that way.
 - iii. Experience your Feelings
 - 1. Notice that emotions leave and return.
 - 2. Try not to push the emotion out of your awareness.
 - 3. Don't try to distance yourself from feelings or make excuses.
 - 4. Don't try to hang onto those feelings or force them.
 - iv. Embrace your feelings
 - 1. Try to notice them without judging yourself for having them.
 - 2. At that point, you can accept the presence of that emotion.
4. *Recognize your need for relational value.* Although the relationships with the primary caregivers (e.g. parents) form the basis of our relationship system, as we develop and grow, we must interact with and form relationships with many different kinds of people. We monitor our relationships in terms of relational value. Our relational value is the extent to which we are important to other people and other people care about our interests and about us. Relational value is the extent to which we see ourselves as being known and valued by others.
- a. As human beings, we all have a core need for relational value and we get that need met by the important others in our lives.
 - b. You describe that there are aspects of yourself that you typically have not felt comfortable sharing. In order to deepen your relationships and increase your relational value, you might consider sharing with important others the difficult emotions that you tend to hide.
 - c. By recognizing your relational need, you might also recognize that you would benefit from forming deep friendships on campus. Consider opening up to a friend when you feel overwhelmed with schoolwork or in the event that you experience a conflict. You might also consider sharing some of the details of your life before college.
 - d. Keep in mind that interacting in a new way with others can feel strange and anxiety provoking at first; however, just like working out a new muscle, individuals typically feel stronger and more confident with their new skills over time. All the while, attempt to be as much “yourself” as you can be.

Appendix M: Case Study #4- “Diane”

Participant: 3474

Date of Feedback Session: REDACTED

Researcher/Clinician: Gregg Henriques, PhD



The Psychological Check-Up

The purpose of this evaluation was to conduct a psychological “check-up”, which is designed to offer you an assessment of your psychological well-being, personality traits, identity, and adaptive tendencies. We have gathered information through surveys and an in-person interview and seek here to share with you the major findings and offer you a narrative of your overall functioning.

Note that this is an “unofficial” document that was developed in the context of a research project at James Madison University and is not part of an official policy or evaluation, but rather is solely intended for enhancing the individual’s awareness and should be used to the extent it fosters that and not considered for any official purposes.

Major Finding #1: Your overall psychological well-being was found to be “Mixed to Somewhat High”, which is slightly below the averaged reported well-being of JMU college students.

Psychological well-being refers to the extent to which one is satisfied with their life, is able to control their environment, has positive relations, and the extent to which they tend to experience positive relative to negative emotions. Your overall level of well-being was found to be in the “Mixed to Somewhat High” range. In particular, your sense of academic functioning, personal growth, and health and fitness were good. However, you did not feel high levels of environmental mastery, autonomy or emotional health. During our review of your life history you revealed some questions about where your life was headed, stressors about what the next phase of life might bring and some notable struggle with negative emotions.

Major Finding #2: You’ve been experiencing significantly high levels of anxiety, which are difficult to control and predict.

You shared that over the past year you have been dealing with notably upsetting episodes of anxiety. Although these were not necessarily full-blown panic attacks, they have been very distressing and difficult to control and predict. The results from both the quantitative measures and the interview are suggestive of clinically significant levels of anxiety (i.e., would likely warrant an official diagnosis). The domains include experiencing unpredictable anxious reactions (e.g., in school), generalized feelings of tension and worry, and social anxiety in the form of anticipating what other might think of you or how you might be judged.

Major Finding #3: You have developed many good friendships and currently have good relationships with your parents; however, you do have a tendency toward being a bit dependent on others and look to others for guidance and have not developed as full a sense of who you want to be as might have otherwise been the case.

You scores and narrative suggested that you connect well with others, are affiliative and agreeable much of the time, and enjoy being part of a group. However, you do not have a self-concept of being a strong, powerful or gifted individual. Indeed, although you can be assertive, your sense of yourself, in terms of your philosophy of life or long term vision or values was somewhat less developed than it might be. It seems that you have looked to others to belong, but that you have not fully developed a clear narrative regarding who you want to be and why.

A Brief Historical Narrative of Key Events

In general, you reported a happy life, including a good childhood with close family ties and currently good relationships with both your parents. You noted a time when your parents had some significant conflict, and although that time has passed, it did appear that there may have been some unresolved questions about that period, especially in relationship to your connection with your mother.

Life at JMU has generally been quite happy for you. You were largely successful in the academic sphere and found a number of good friends and have enjoyed both the course work and the social life, as well as found a number of opportunities for personal growth. Relationally, you have a multitude of good connections, and both in the interview and on the measures, you scored high on relational value, which is the sense of being known and valued by important others. It is worth noting, however, your time at JMU is nearing an end, and it is uncertain what the next chapter will bring. In addition to anxiety associated with a bit of uncertainty, you have been experiencing clinically significant levels of anxiety since the summer. You attempted to address and attended the Counseling Center's group for managing anxiety, but this did not seem to address the issue. During the interview, you reported a notable history regarding a very distressing relationship with "friend" who at times traumatized you, both physically and verbally and remains a source of concern for you today. It seemed that there were some emotional scars associated with this experience that remained unprocessed and unresolved.

You anticipated going on to graduate school, perhaps in some ways as an extension of college. However, you were not successful in your application and that has triggered some notable uncertainty in you. In the context of our discussion about your life and life trajectory, it seemed possible that you had not delved deeply into your future adult identity, but really were more going through the motions of what might be expected. As such, it seems you are at an important developmental juncture whereby you will need to consider deeply who you are and who you want to be.

Recommendations:

Based on the above formulation of your well-being and character functioning, the following recommendations are made:

1. *Psycho-education and Self-Help*. Our society does not always do an excellent job educating folks about their feelings and coping styles. There were some suggestions that you might benefit from understanding of negative emotions better. As such we recommend you consider the following work:
Kashdan, T., & Biswas-Diener, R. (2014). *The upside to your dark side*. New York, NY: Harper Collins.

In addition, anxiety often involves both fear and the fear of fear, meaning that we not only fear certain stimuli like social settings, but we come to fear our fearful reactions. You might benefit from some self-help designed to teach folks about anxiety, such as:

Forsyth, J. Eifert, G., (2005) *The Mindful & Acceptance Workbook for Anxiety*.

2. *Career Counseling*. On the heels of not getting into graduate school, it seemed you had lots of questions about who you were and what professional opportunities might be afforded you. Given your level of uncertainty, you might consider receiving some career counseling (JMU gives free career advice), in addition to some more general reflection about how you might like your life to unfold.
3. *Psychotherapy*. Although you have tried some group work in the past, you might consider individual psychotherapy for both your anxiety and to help develop a stronger identity about your values and vision for your life. Although I realize it might not work because of your completing school, the Counseling and Psychological Services (CAPS) is available for longer-term psychotherapy, if you will be in the area.

Counseling and Psychological Services (CAPS)

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601 University Blvd.

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Phone: 540-568-1735

<http://www.iihhs.jmu.edu/caps/index.html>

If you have any questions or concerns about this process, please contact Dr. Gregg Henriques at henriqgx@jmu.edu, or Lindsay Anmuth, MA, at anmuthlm@dukes.jmu.edu.

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